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

IDHS Office of the Inspector General

FY21 Annual Report

December 10, 2021

To Governor Pritzker and Members of the Illinois General Assembly:

The word that best describes the 2021 fiscal year for the Illinois Department of Human Services Office of the Inspector General (OIG) is perseverance. Although the COVID-19 pandemic impacted all aspects of OIG's investigative and administrative operations, *see infra* Chapter 1(B), the Office was still able to function as an effective watchdog for individuals with developmental disabilities and individuals receiving mental health services at State-operated facilities and community agencies licensed, funded or certified by the Department.

The following metrics demonstrate that FY21 was a successful year for OIG, as the Office was able to:

- Reduce by 26 percent the amount of investigations that have been open for over 60 days;
- Reduce the number of State facility staff that were on paid administrative leave as a result of OIG investigations by 29 percent; and
- Reduce its overall caseload by 18 percent, while also making findings of abuse and neglect at an increased rate, and modestly increasing the percentage of investigations OIG completed within 60 days.

OIG also engaged in multiple legislative and rule-based initiatives to ensure that these positive trends continue. On the legislative front, the statutory amendment that OIG proposed in FY21—which allows State-operated facilities to return employees to work more quickly when OIG determines that the allegations against them will be unsubstantiated or unfounded in its final investigative report—was signed into law in August 2021 and will go into effect on January 1, 2022. With respect to its internal policies, OIG implemented new timeliness requirements regarding the interviews of victims and complainants, that are designed to help OIG complete its investigations in a more efficient manner.

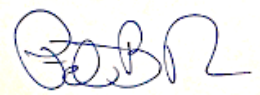
That OIG was able to accomplish so much in FY21 is especially notable given that OIG also completed the most complex and significant investigation in OIG's recent history: the examination of the tragic COVID-19 outbreak at the LaSalle Veterans' Home. OIG, working with outside counsel, devoted significant resources to assessing the Illinois Department of Veterans' Affairs (IDVA) and the LaSalle Home's preparation for and response to the outbreak. In its summary

report, OIG made nine recommendations to IDVA as to how it could prevent future outbreaks by modifying its infection control policies and practices, and IDVA accepted all nine of OIG's recommendations.

OIG is proud of the above-described accomplishments but also understands that it cannot let up in its efforts to protect the vulnerable populations OIG serves. Accordingly, OIG will continue striving to produce timely, comprehensive, and effective investigative and analytic work.

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

Sincerely,



Peter B. Neumer
Inspector General

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Chapter 1: Summary of OIG's FY21

A. Notable FY21 Data

The FY21 data demonstrates that OIG was able to build on its FY20 successes and again make significant improvements in terms of its productivity and timeliness. Most notably, OIG:

- Reduced its overall caseload from 1407 to 1192, a reduction of 18 percent;
- Reduced the number of OIG investigations that have been open more than 60 days from 1,032 to 766, a reduction of 26 percent;
- Increased the percentage of cases completed within 60 days from 47 percent in FY20 to 50 percent in FY21;
- Helped reduce the number of facility employees on paid administrative leave due to OIG investigations that extend beyond 60 days by almost 30 percent. *See infra* Chapter 1(C) for additional information regarding OIG and paid administrative leave.

For a more complete detailing of OIG's FY21 metrics, *see infra* Chapters 2 & 3.

B. COVID-19's Impact on OIG

Due to COVID-19, FY21 was operationally similar to the end of FY20 for OIG, meaning that OIG continued to conduct the majority of its investigations and site visits remotely. OIG had hoped to return to on-site investigations sooner, but, given the vulnerable populations OIG serves, and following consultation with IDHS and State medical experts, OIG determined that such a return was not prudent.

With respect to OIG's COVID-19 related investigations, from July 1, 2020 until June 30, 2021, OIG received 50 allegations of abuse or neglect related to COVID-19. As of October 2021, OIG completed 40 of those investigations and substantiated neglect in 4 of those investigations. OIG identified other issues that required a written response from the agency or facility in 14 of those 50 cases.

Below are deidentified, narrative summaries of the four COVID-19-related cases that OIG opened and completed in FY21, or opened in FY21 and completed in FY22, and in which OIG substantiated neglect.

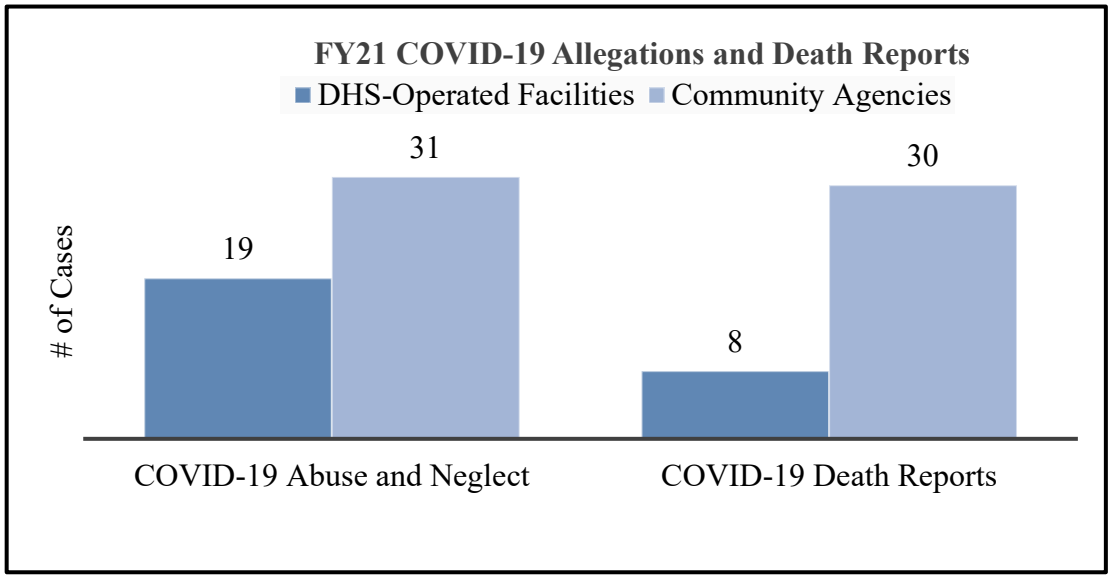
1021-0100 – OIG substantiated a finding of neglect where its investigation established that an employee worked for several hours after they falsely stated that they had not had contact with a person who had tested positive for COVID-19, even though they had been in contact with their COVID-19 positive partner. The employee resigned prior to the completion of OIG's investigation.

1221-0115 - OIG substantiated a finding of neglect where its investigation established that an employee failed to consistently and appropriately wear their personal protective equipment and allowed an individual quarantined due to COVID-19 exposure to be out of the individual's room and around other individuals in the home. The employee was terminated prior to the completion of OIG's investigation.

1221-0142 – OIG substantiated a finding of neglect where its investigation established that an employee reported to work even though the employee had COVID-19 symptoms and was COVID-19 exposed, and failed to notify supervisors of a fever after taking a temperature reading upon arrival to work. The employee was subsequently retrained on COVID-19 policy.

1621-0090 – OIG substantiated a finding of neglect where its investigation established an employee was allowed to work multiple shifts after the employee tested COVID-19 positive, experienced coughing and shortness of breath, and, on occasion, failed to wear a mask while working. The employee was subsequently coached on PPE use and COVID-19 symptom-reporting requirements.

OIG also received 41 reports of COVID-19 related deaths in FY21. As of October 2021, OIG completed reviews of 26 of the 41 deaths and identified issues that required a written response from the agency or facility in 2 of the reviews. With respect to the 26 completed death reviews, OIG subsequently opened 6 full investigations, based on a finding that there was a suspicion of abuse or neglect related to the death. Five of those investigations remain open and, in the sixth investigation, OIG reached an unfounded determination. Fifteen reviews of COVID-19-related deaths are still ongoing.



OIG notes that the trend of declining complaints, which began prior to COVID-19, continued in FY21, as OIG received 17 percent less complaints in FY21 than in FY20. OIG believes that part of that decline was likely due to the temporary closure of day programs during the pandemic, but acknowledges it is difficult to determine precisely what percentage of the decline is due to COVID-19, versus other factors that existed prior to COVID-19.

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

In FY21, 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 completed, 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 FY21, 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, including the following:

- Worked with IDHS's legislative team to amend 405 ILCS 5/3-210 of the Mental Health and Developmental Disabilities Code. As a result of this amendment, OIG will be able to more quickly return employees to work when OIG has determined that the allegations against them will be unsubstantiated or unfounded in its final investigative report.
- Held monthly meetings with Bureau Chiefs to prioritize the completion of investigations that involved facility employees who had been placed on paid administrative leave or reassignment.
- Successfully collaborated with IDHS' Division of Developmental Disabilities (DDD) to draft a directive for facilities that provides additional guidance as to when facility employees are to be placed on administrative leave.

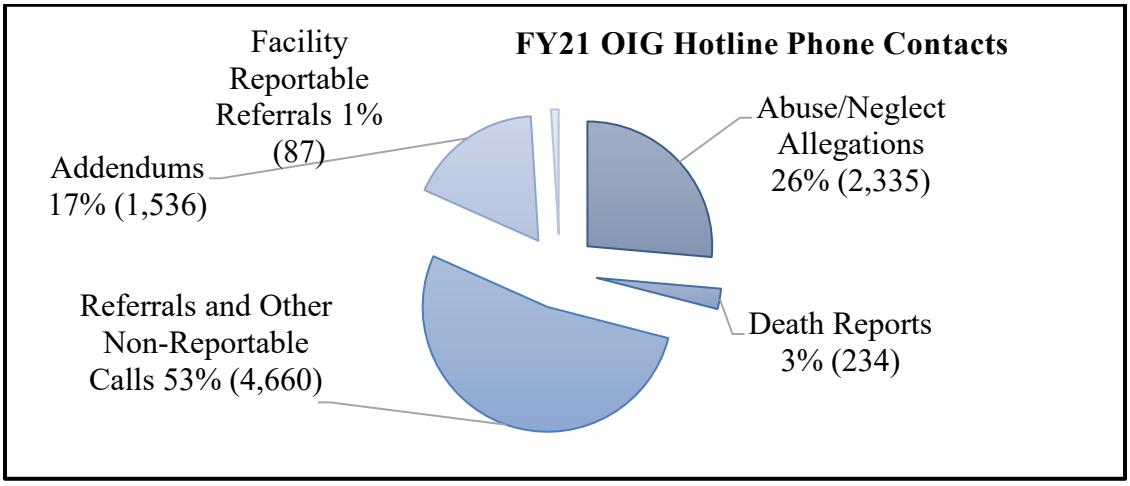
Based on the figures provided by DDD, as DDD maintains the records and data regarding facility administrative leave, these efforts were a success, as the number of facility employees on paid administrative leave due to OIG investigations (excluding the employees on paid administrative leave due to criminal investigations or proceedings) dropped from 55 on July 1, 2020 to 39 on June 30, 2021, a reduction of nearly 30 percent.

Chapter 2: OIG's FY21 in Numbers

A. OIG Hotline Calls and Referrals

During FY21, the OIG's Intake Bureau processed 8,852 calls, as reflected in the below table. As background, OIG's Intake Bureau is staffed by a Bureau Chief, an Investigative Team Leader, and 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.

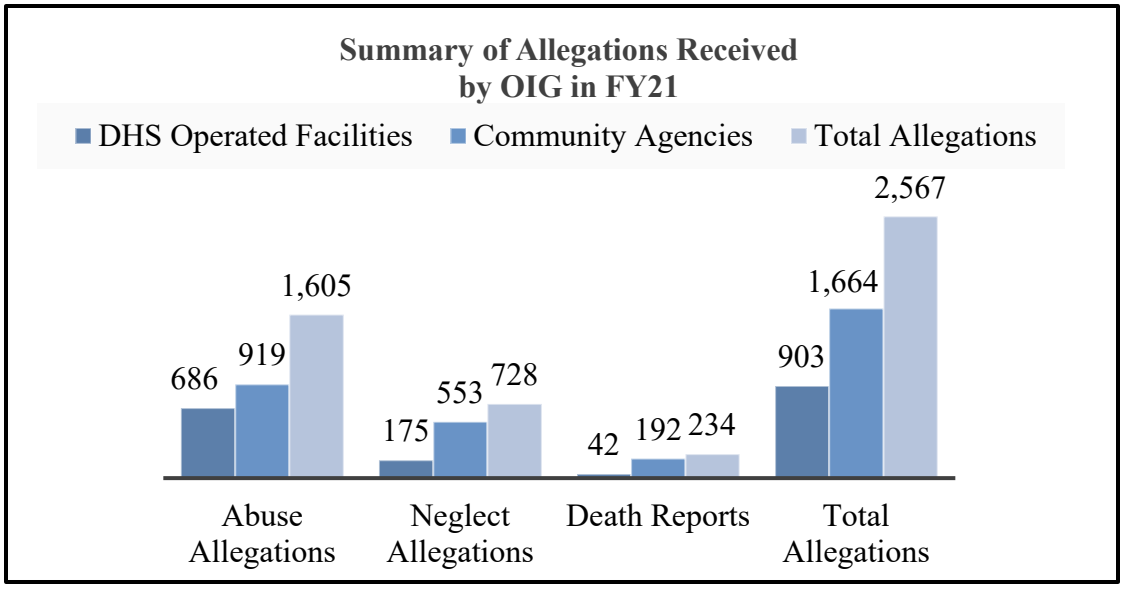
OIG receives complaints alleging abuse (physical abuse, sexual abuse, mental abuse, and financial exploitation), neglect (neglect and egregious neglect), as well as death reports (reports of death where abuse and neglect is not suspected). OIG's Complaint Intake Bureau also receives thousands of non-reportable calls, which include complaints that do not fall under the definitions set forth in 59 Ill. Admin. Code 50 ("Rule 50"), 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 FY21, OIG had 4,660 non-reportable calls. The following table reflects the recipients of OIG's FY21 referrals:

Referral Location	Total Referred
Local Community Agency or Facility	68% (2047)
Illinois Department of Public Health	10% (308)
Department on Aging	3% (96)
IDHS Division of Developmental Disabilities	1% (41)
Department of Children and Family Services	1% (40)
DHS BALC/OCAPS	1% (28)
Department of Healthcare and Family Services	1% (26)
Law Enforcement	1% (24)
IDHS Division of Rehabilitation Services	Less than 1% (10)
IDHS Division of Mental Health	Less than 1% (7)
Other	13% (400)
Total Referred	**3,027**

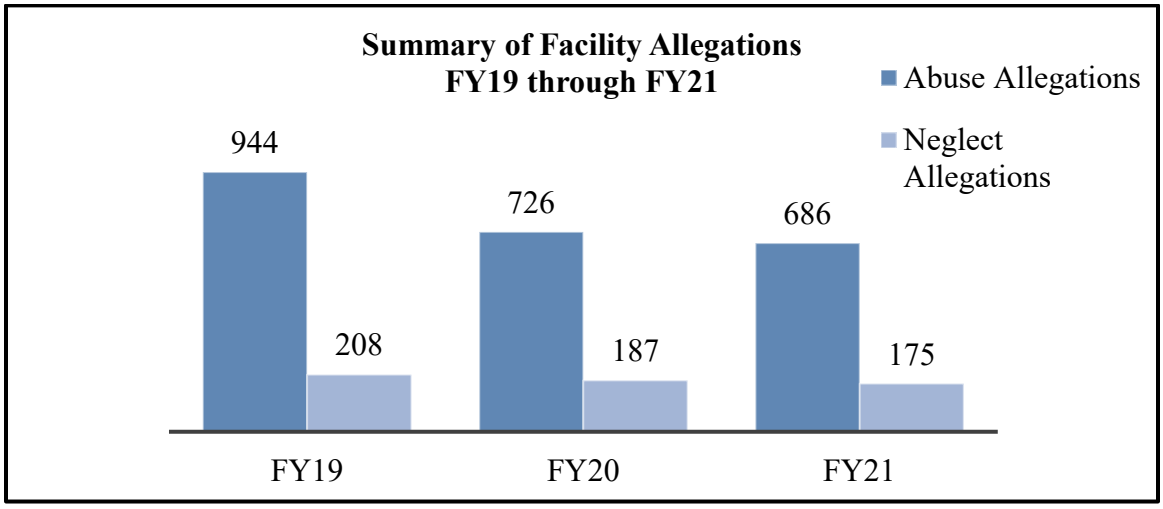
B. Allegations of Abuse and Neglect Received



During FY21, OIG received a total of 2,333 allegations of abuse or neglect, 467 fewer than in FY20. The following tables provide a detailed breakdown of the allegations OIG received in FY21,by type and location. Total abuse allegations in IDHS-operated facilities and community agencies decreased from 1,914 in FY20 to 1,605 in FY21. Allegations of financial exploitation also decreased by 30.5% from FY20 to FY21. Similarly, neglect allegations in IDHS-operated facilities and community agencies decreased by 17.8% from FY20 to FY21.

Facilities

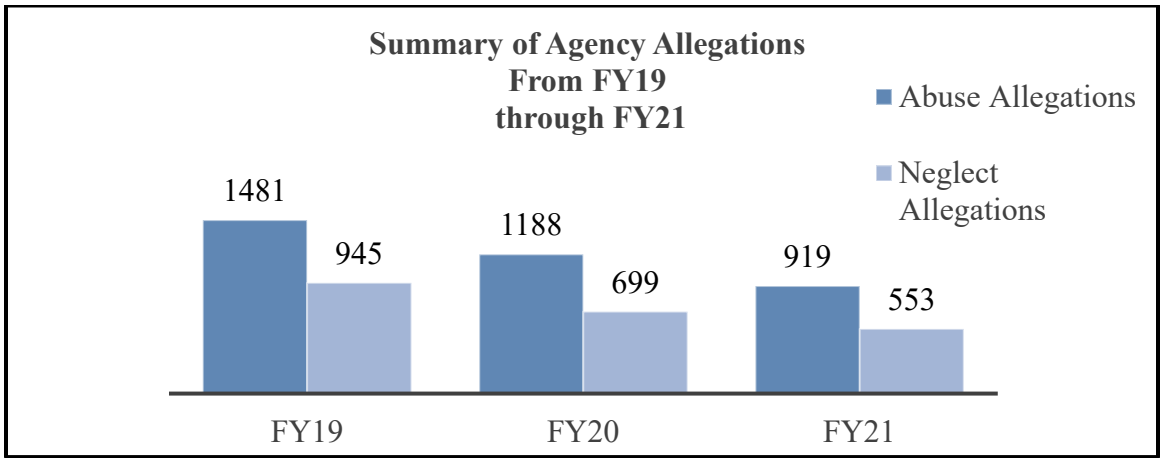
During FY21, OIG received 861 allegations of abuse and neglect at the IDHS-operated facilities,a 5.6% decrease from FY20. 686 of the 861 facility allegations were allegations of abuse (which allegations included 28 allegations of financial exploitation). Abuse allegations accounted for 79.6% of the total allegations at facilities, essentially the same percentage as FY20. 175 of the 861 facility allegations OIG received in FY21 were allegations of neglect. The number of FY21 neglect allegations decreased by 6.4% from FY20.



Community Agencies

During FY21, OIG received 1,472 allegations of abuse and neglect at community agencies, a 21.9% decrease from FY20. Of the 1,472 community agency allegations, there were 919 allegations of abuse, including 16 allegations of financial exploitation. In FY21, 55.7% of the community agency allegations OIG received were abuse allegations, compared with 63% in FY20, and 61% in FY19. OIG received 728 allegations of neglect at community agencies in FY21, a 4.1% increase from the 699 neglect allegations OIG received in FY20.

In FY21, allegations at community agencies accounted for 63% of the total allegations OIG received. This number is generally reflective of the fact that significantly more individuals receive MH/DD services at community agencies than at State-operated Facilities.



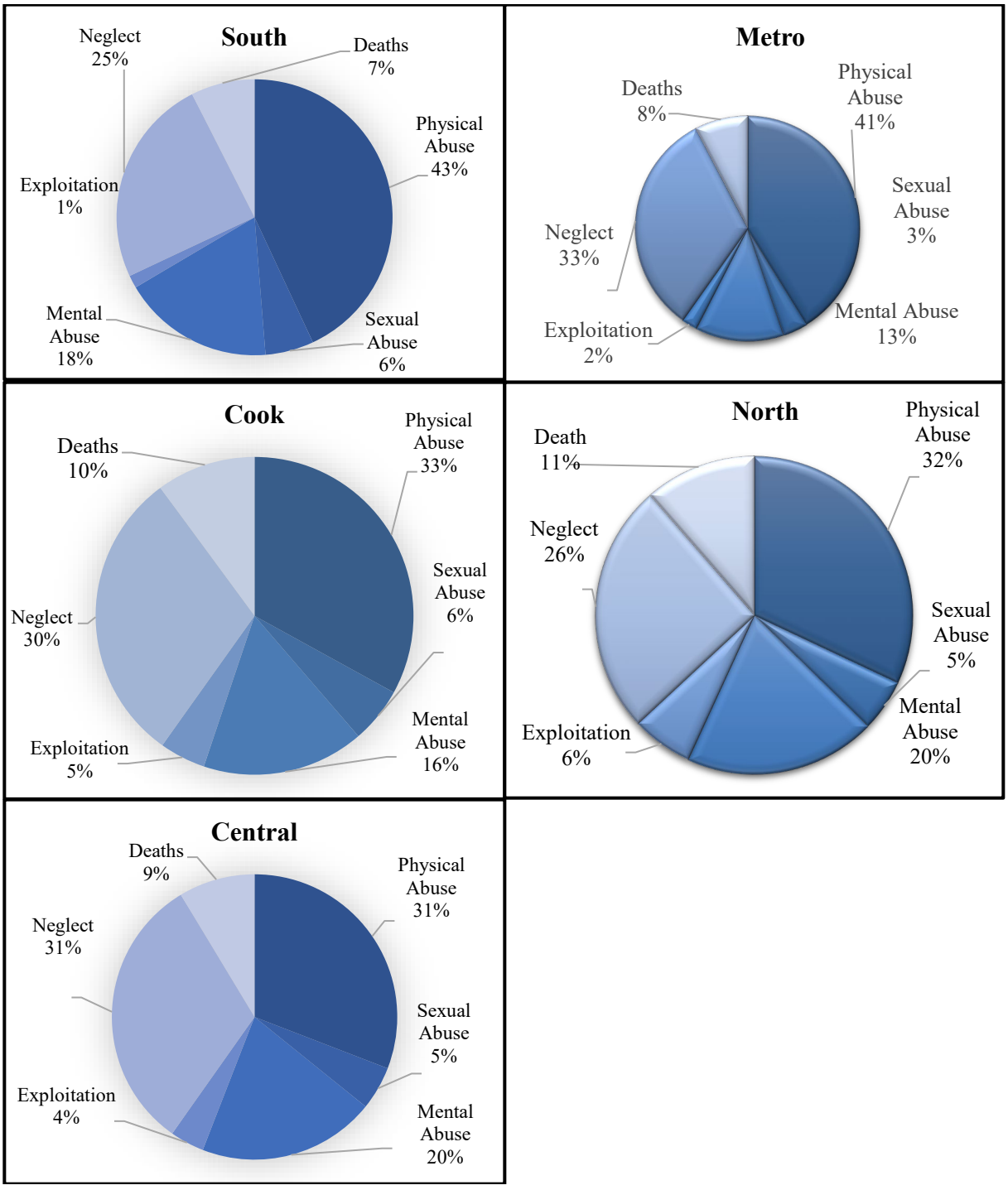
Allegation Type

The following tables show the allegations of abuse and neglect and death reports that OIG received during FY21, categorized by the type of allegation and program location. In addition to the above-described abuse and neglect allegations that OIG received, during FY21, OIG received death reports regarding 234 individuals who were or had been receiving MH/DD services in facility or community agency programs.

FY21 Allegations and Death Reports Received by Mental Health Location							
Location	Allegations Received						Death Reports
	Physical Abuse	Sexual Abuse	Mental Abuse	Financial Exploitation	Neglect	Total	
Mental Health Centers							
Alton	27	4	23	8	14	76	0
Chester	64	6	20	1	15	106	2
Chicago-Read	21	6	9	0	8	44	2
Choate	14	4	6	0	4	28	0
Elgin	33	15	22	14	14	98	6
Madden	3	1	6	1	8	19	1
McFarland	17	4	7	4	5	37	2
Facility Totals	**179**	**40**	**93**	**28**	**68**	**408**	**13**
Community Agencies:							
Residential	9	13	20	8	14	64	17
Non-Residential	2	9	12	8	4	35	3
Agency Totals	**11**	**22**	**32**	**16**	**18**	**99**	**20**
Total Allegations and Reports	**190**	**62**	**125**	**44**	**86**	**507**	**33**

FY21 Allegations and Death Reports Received by Developmental Center Location							
Location	**Allegations Received**						**Death Reports**
	Physical Abuse	**Sexual Abuse**	**Mental Abuse**	**Financial Exploitation**	**Neglect**	**Total**	
Developmental Centers:							
Choate	96	12	51	2	34	195	1
Fox	1	0	0	0	4	5	4
Kiley	50	3	23	0	21	97	4
Ludeman	29	0	8	0	32	69	3
Mabley	7	0	2	1	1	11	4
Murray	22	0	2	0	12	36	7
Shapiro	31	3	3	0	3	40	6
Center Totals	**236**	**18**	**89**	**3**	**107**	**453**	**29**
Community Agencies:							
Residential	486	44	225	45	518	1318	171
Non-Residential	16	7	14	1	17	55	1
Agency Totals	**502**	**51**	**239**	**46**	**535**	**1373**	**172**
Total Allegations and Reports	**738**	**69**	**328**	**49**	**642**	**1826**	**201**

Allegations by Bureau

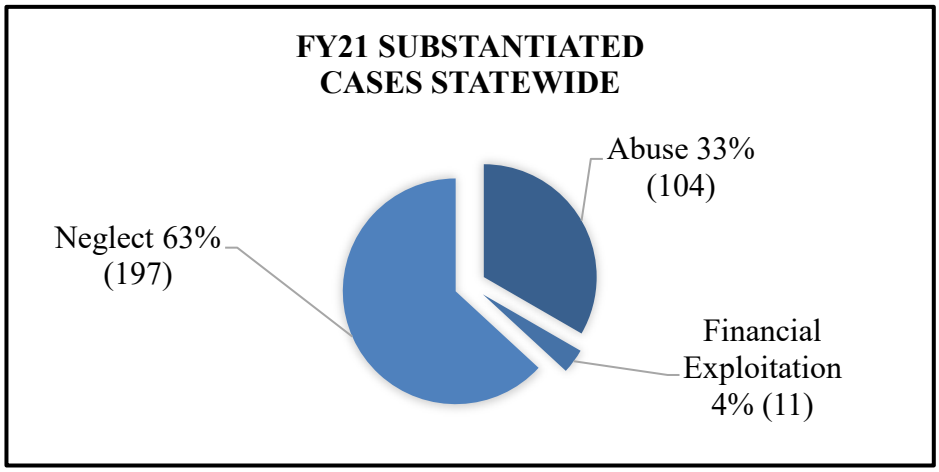


C. Findings

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 312 of the 2,702 investigations it closed in FY21, including197 substantiated neglect cases, 104 substantiated abuse cases, and 11 financial exploitation cases.The below tables reflect: (1) FY21 Substantiated Cases Statewide by Category; (2) Substantiated Abuse and Neglect Cases by MH Location; and (3) Substantiated Abuse and Neglect Cases by MH Location.



FY19 through FY21 Substantiated Case Trends

OIG's overall substantiation rate increased from 9.4% in FY20 to 11.55% in FY21. In FY21, OIG substantiated cases at a higher rate in all settings than in FY20.

OIG substantiated 6 more abuse cases at DD community agencies in FY21 than FY20, and 2 more neglect cases.

Substantiation Rate - FY19 through FY21			
Location	**FY19**	**FY20**	**FY21**
MH State Facility	3.1%	2.9%	4.55%
DD State Facility	4.7%	3.6%	5.65%
MH Community Agency	5.4%	6.1%	8.77%
DD Community Agency	10.3%	12.5%	15.33%
Total	**7.9%**	**9.4**	**11.55**

FY21 Findings by Mental Health Location					
Location	**Abuse Substantiated**	**Financial Exploitation Substantiated**	**Neglect Substantiated**	**Not Substantiated**	**Findings Total**
Mental Health Centers					
Alton MHC	1	0	3	48	52
Chester MHC	3	0	6	113	122
Chicago-Read MHC	1	0	1	41	43
Choate MHC	0	0	0	28	28
Elgin MH	0	0	1	100	101
Madden MHC	1	0	2	24	27
McFarland MHC	0	0	0	37	37
Center Totals	**6**	**0**	**13**	**391**[1]	**410**
Community Agencies					
Residential	3	0	3	54	60
Non-Residential	0	1	3	33	37
Agency Total	**3**	**1**	**6**	**87**	**97**
Finding totals	**9**	**1**	**19**	**478**	**507**

[1] OIG made recommendations to the facility in 41 of the 391 MH cases that OIG did not substantiate.

FY21 Findings by Developmental Location					
Location	**Abuse Substantiated**	**Financial Exploitation Substantiated**	**Neglect Substantiated**	**Not Substantiated**	**Findings Total**
Developmental Centers					
Choate DC	1	0	3	163	167
Fox DC	0	0	1	4	5
Kiley DC	0	0	1	88	89
Ludeman DC	6	0	10	81	97
Mabley DC	0	1	2	15	18
Murray DC	2	0	2	50	54
Shapiro DC	0	0	0	48	48
Center Totals	**9**	**1**	**19**	**449[2]**	**478**
Community Agencies					
Residential	81	9	140	1184	1414
Non-Residential	7	0	13	83	103
Agency Total	**88**	**9**	**153**	**1267**	**1517**
Finding totals	**97**	**10**	**172**	**1716**	**1995**

FY21 Substantiated Death Cases

OIG closed 199 death cases during FY21, an increase from the 188 death cases OIG closed during FY20. Of the 199 closed death cases, OIG determined that there was no suspicion of abuse or neglect in 169 of the cases. With respect to the 30 death cases where OIG subsequently opened an abuse or neglect investigation, OIG substantiated 4 cases for neglect. As to the other 26 cases that OIG did not substantiate, OIG identified issues that required a written response from the agency or facility in 23 of those cases.

D. Reconsiderations of OIG Findings

In FY21 OIG received and reviewed 101 requests for reconsideration of OIG's investigative findings or recommendations, in connection with 98 investigations (an investigation will sometimes result in multiple requests for reconsideration). As background, pursuant to Illinois statutory law, facilities, agencies, victims, guardians, or subject employees can request that OIG reconsider the findings or recommendations OIG made in its investigative report. 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:

[2] OIG made recommendations to the facility in 70 of the 499 DDD cases that OIG did not substantiate.

- 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.

In FY21, OIG received fewer reconsiderations than in FY20, but granted a similar percentage of those requests. Of the 123 reconsiderations OIG received in FY20, OIG denied 73% and granted 28%. Of the 101 reconsiderations OIG received in FY21, OIG denied 71% and granted 29%, as reflected in the below table

FY21 Reconsideration Outcomes	Number of Cases	Outcomes in Percentages
Denied	66	65%
Denied, with the Issuance of an Amended Report	6	6%
Granted, with the Issuance of an Amended Report	19	19%
Granted, and Reopened Investigation	10	10%
Total Reconsiderations	**101**	

FY20 Reconsideration Outcomes	Number of Cases	Outcomes in Percentages
Denied	82	67%
Denied, with the Issuance of an Amended Report	7	6%
Granted, with the Issuance of an Amended Report	26	21%
Granted, and Reopened Investigation	8	6%
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 (DDD or DMH). *See* Department of Human Services Act, 20 ILCS1305/1-17(n). The program division then reviews and approves the written responses and sends the written response to OIG.

In FY21, OIG received 97 approved written responses from facilities and 573 from community agencies for a total of 670 written responses, regarding OIG's findings and recommendations.[3] With respect to the above-described written responses, facilities and agencies detailed the following actions related to OIG's findings and recommendations:

FY21 Actions Taken			
Personnel Action		**Administrative Actions**	
Discharged	224	**Individual Retraining**	308
Resignations	68	**Group Retraining**	242
Written Reprimands	71	**Policy/Procedural Change**	121
Counseling	55	**Treatment Plan Change**	50
Suspension	22	**Administrative Change**	23
Transferred	7	**No Action**	5
Written Reprimand	71	**Structural Change**	4
		Supervision	4
		Performance Evaluation	52

F. Compliance Reviews

Once IDHS' DDD and DMH 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. OIG selects a random sample of at least 10% of the written responses approved by the respective divisions during the prior month. OIG then, if necessary, can request documents/records or conduct 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 FY21 by location and program division:

FY21 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	97	19	20%	42	7	17%
Community Agencies	573	82	14%	8	3	38%
Totals	**670**	**101**	**15%**	**50**	**10**	**20%**

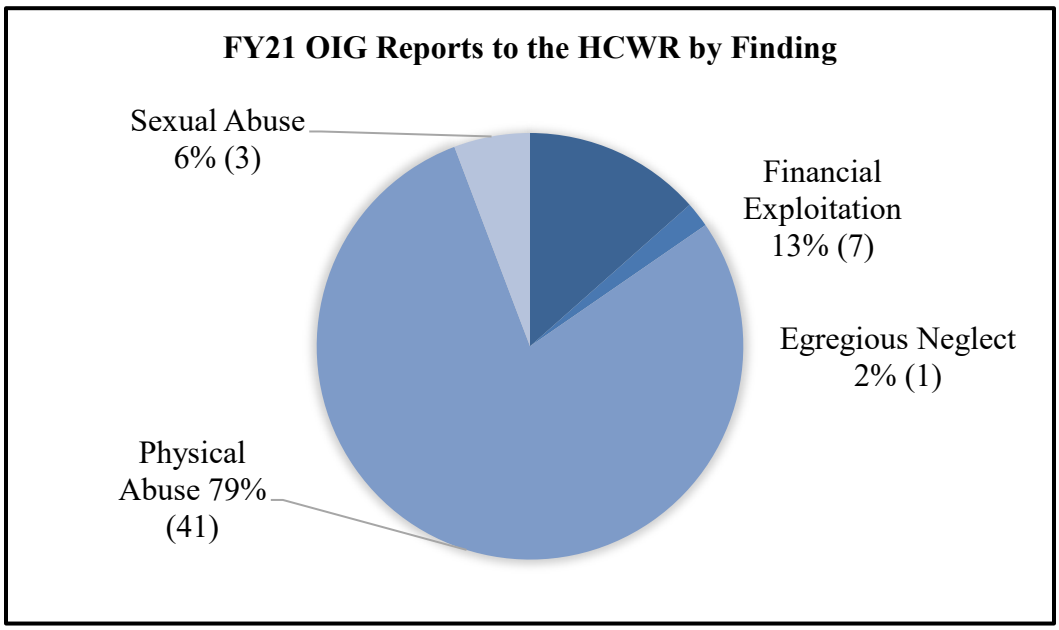
[3] These numbers include approved written responses OIG received in FY21 regarding cases it completed in FY20.

With respect to these 121 compliance reviews, OIG issued two "Out of Compliance" letters to DDD community agencies in FY21.

G. Health Care 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, makes an initial report to the Illinois Department of Public Health's Healthcare Worker Registry (HCWR) of the employee's name and the nature of OIG's finding. Pursuant to Illinois statute, health care employers are prohibited from employing an individual in any capacity "who is identified by the [HCWR] as having been subject of a substantiated finding of abuse or neglect of a service recipient." *See* 20 ILCS 1705/7.3. Following OIG's initial report to the HCWR, the employee can request an administrative hearing to determine if their conduct in fact warrants reporting to the Registry. *See* 20 ILCS 1305/1-17(s)(2) and 59 Ill. Admin. Code 50.90.

During FY21, OIG closed 72 substantiated cases which required initial reports to the HCWR of the employee's name and the nature of OIG's finding. During FY21, OIG made final reports to the HCWR of 52 employees' names and findings,[4] meaning either the employee did not appeal the report or, after a hearing, it was determined that the conduct warranted the reporting.[5] 51 of the reported employees were from the DDD and 1 reported employee was from the DMH. For FY21, OIG's reports to the HCWR placements by finding are reflected in the below table:



[4] There were 55 actual findings because three employees had two substantiated HCWR cases.
[5] Notably, of the 52 placements, 9 placements resulted from OIG investigations completed in previous years and 43 placements resulted from OIG investigations completed in FY21.

HCWR Administrative Hearings

If an employee requests an administrative appeal of OIG's HCWR referral, IDHS has to prove bya preponderance of the evidence that OIG's finding of abuse or neglect warrants the reporting of the employee to the HCWR. During FY21, 13 employees filed appeals challenging their names and findings being reported to the HCWR. All 13 of those appeals remain pending, as new HCWR hearings continued to be suspended due to COVID-19 restrictions.

Four appeals filed prior to FY21 were decided. Two employees lost their appeals and had their names and findings reported to the HCWR; one employee successfully appealed and did not have their name and finding reported to the HCWR. OIG stipulated to one case, meaning that OIG and IDHS agreed that the circumstances surrounding OIG's findings did not warrant the reporting of the employee's name and finding to 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:

- 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 FY21, four employees requested hearings to have their names and findings removed from the HCWR. Those four cases remain pending. One employee, who filed an appeal in FY20, participated in a telephonic hearing in FY21, and their name was subsequently removed from the HCWR.

Arbitrations

Following the completion and issuance of a substantiated OIG investigative report, certain employees (typically those working at IDHS facilities) have the ability to request labor arbitrations, in which the employees challenge administrative actions based on OIG's cases and findings. During FY21, OIG received the results of four labor arbitration requests. Two were decided at the same full arbitration hearing and two were resolved prior to arbitration.

- At the arbitration hearing, two employees were issued Written Warnings for failure to follow facility policies and procedures. Their discharges were set aside, and they were reinstated to their former positions.

- One employee's discharge was reversed, and the employee was afforded the opportunity to return to employment. The employee received a five-day suspension and back pay, as if they were on the payroll during the entire arbitration process.
- One employee's discharge was overturned. The employee received a 30-day unpaid suspension and a loss of seniority.

H. Site Visits

OIG conducts annual 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. *See* Department of Human Services Act, 20 ILCS 1305/1-17(i).

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. OIG uses the Principals and Standards for Offices of Inspector General promulgated by the Association of Inspectors General as guidance for its site visit methodology. Due to the COVID-19 pandemic, and in accordance with Illinois Department of Public Health mitigation efforts, OIG conducted site visits remotely in FY21.

FY21 Scope

The scope of OIG's FY21 site visit consisted of a review of key processes and procedures related to individuals who received 1:1 supervision in a facility operated by the Division of Developmental Disabilities or 1:1 special observation in a facility operated by the Division of Mental Health during FY20. These processes included:

- The supervision level in the Annual Assessment conducted by the Interdisciplinary Team or Treatment Team;
- The Individual Support Plan, Behavior Support Plan, or Treatment Plan process for documenting level of supervision or special observation;
- The communication of supervision levels to responsible staff persons;
- The assessment of Staff knowledge regarding Staff responsibilities when providing 1:1 supervision or 1:1 special observation;
- Physician/medical staff actions as they pertain to medical conditions requiring 1:1 supervision or 1:1 special observation; and
- Staff training regarding 1:1 supervision or 1:1 special observation.

OIG conducted remote site visits at each facility on the following dates:

Alton Mental Health Center	December 8, 2020 – March 2, 2021
Chester Mental Health Center	January 26, 2021 – April 22, 2021
Chicago Read Mental Health Center	January 21, 2021 – May 15, 2021
Choate Developmental Center	January 12, 2021 – March 15, 2021
Choate Mental Health Center	January 12, 2021 – March 15, 2021
Elgin Mental Health Center	January 20, 2021 – May 29, 2021
Fox Developmental Center	December 8, 2020 – February 26, 2021

Kiley Developmental Center	December 22, 2020 – April 20, 2021
Ludeman Developmental Center	December 9, 2020 – March 12, 2021
Mabley Developmental Center	December 9, 2020 – March 12, 2021
Madden Mental Health Center	December 23, 2020 – May 11, 2021
McFarland Mental Health Center	December 10, 2020 – March 1, 2021
Murray Developmental Center	January 13, 2021 – May 18, 2021
Shapiro Developmental Center	January 19, 2021 – June 21, 2021

OIG requested pertinent documents in September 2020. OIG then had an entrance conference with staff from each facility during December 2020 and January 2021. The OIG site-visit team reviewed relevant documentation, requested any additional information not gathered during the initial request phase, and interviewed appropriate personnel to discuss their roles in the enhanced supervision process and clarify any outstanding questions.

Prior to the exit conference, OIG provided each facility with a draft report, indicating any recommendations and opportunities for improvement. Opportunities for improvement are issues OIG identified during the site visit that do not rise to the level of a recommendation, but which OIG believes should be brought to the attention of the facility for their administrative review and action, as deemed necessary. The facility had 10 working days to respond to the document, including an opportunity to submit any response in writing for inclusion in the final report. Following a formal exit conference, the facility had 60 working days to provide a status update on any of the remaining actions necessary to address the recommendation.

Summary of Recommendations

In FY21, OIG made 35 recommendations and noted 11 opportunities for improvement in its 14 site visit reports. The majority of the recommendations concerned documentation that was missing or not properly recorded, including summary progress notes, specific observation level instructions, signatures of staff, and records of 15-minute checks sign-off. Other recommendations included the following:

- At 5 of the 7 Mental Health Centers, OIG recommended that, pursuant to facility directive, registered nurses transcribe treatment plan information onto Special Observation Reports, which are required for staff to provide appropriate observation to each individual;
- At 4 of the 7 Mental Health Centers, OIG recommended that, pursuant to facility directive, the Treatment Team review all incidents of special observation lasting more than three days, with weekly review thereafter;
- At 3 of the 7 Mental Health Centers, OIG recommended that, pursuant to facility directive, daily face-to-face physician assessments be conducted for those individuals on special observation;
- At 2 of the 7 Mental Health Centers, OIG recommended policy revisions pertaining to conducting face-to-face physician assessments for individuals on special observation.
- OIG made a total of 11 recommendations across all 7 Developmental Centers regarding documentation issues, including the need to complete supervision/monitoring sheets accurately and thoroughly.

- At 2 of the 7 Developmental Centers, OIG identified opportunities for improvement regarding the facilities' internal review of Individual Service Plans and Behavior Intervention Plans to identify and correct inconsistencies.
- At 2 of the 7 Developmental Centers, OIG identified opportunities for improvement regarding continued collaboration with DDD to fully comply with state rules regarding document retention.
- At 2 of the 7 Developmental Centers and 1 of the 7 Mental Health Centers, OIG recommended the facility provide alternative assignments for staff conducting 1:1 duties longer than two hours.

Chapter 3: Additional FY21 Data

A. Reporting Allegations to OIG in a Timely Manner

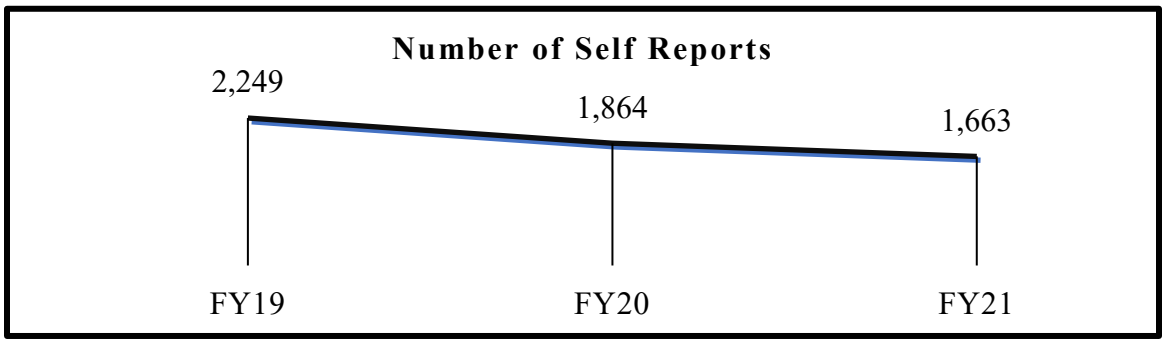
Any employee of a State-operated facility or community agency that falls under OIG's jurisdictionis considered to be a required reporter and must report an abuse or neglect allegation to OIG's Hotline within four hours of their initial discovery of the allegation. OIG refers to these types of reports 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.

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 dayseach report was late, and the overall percentage of reports that were late.

In FY21, OIG received 1,663 self-reported allegations of abuse and neglect, a 10.7% decline from FY20. OIG believes that this decline in self-reports is likely due in part 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 FY21 to 11.37% from 11.1% in FY20. The Illinois Auditor General noted the issue of late reporting in its 2020 Program Audit of OIG. In response, OIG sent a letter and PowerPoint training to all the facilities and community agencies reinforcing the requirement that allegations be reported within 4 hours and outlining the appropriate procedure to report allegations to the OIG Hotline. In addition, OIG continues to send the IDHS program divisions a report of the untimely "self-reports" OIG received in the previous month, which identifies each late report and states the number of days each report was late, and the overall percentage of reports that were late.

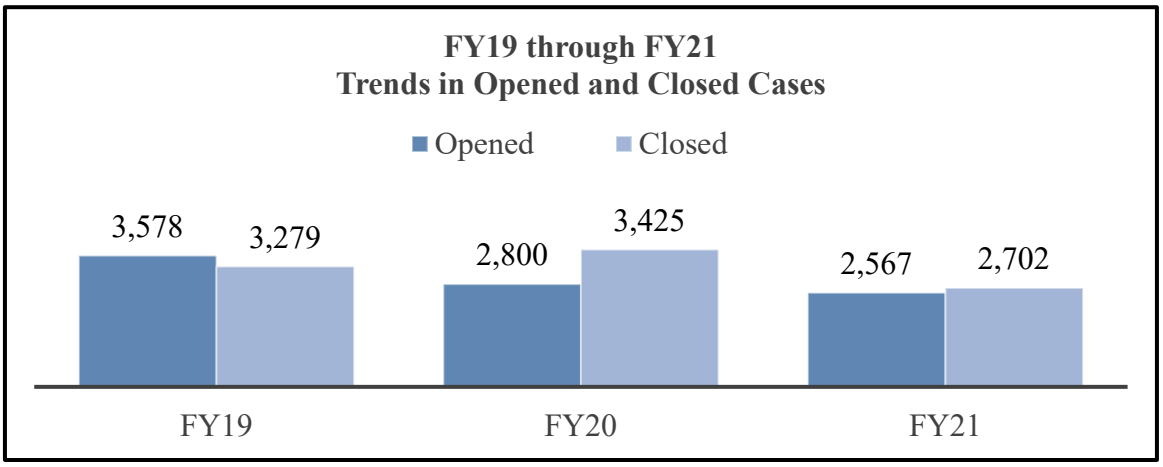
FY19-FY21 Late Reporting by Program and Disability Type						
Fiscal Year	**Late from Agencies**		**Late from Facilities**		**Total Late**	**Percent Late**
	DD	**MH**	**DD**	**MH**		
FY19	170	21	31	18	**240**	**10.7%**
FY20	163	14	17	12	**206**	**11.1 %**
FY21	137	11	25	16	**189**	**11.37 %**

B. Reduction in OIG Caseloads

For the second fiscal year in a row, OIG closed more cases than it opened. More specifically, OIG opened 2567 cases in FY21 and closed 2702, and reduced its overall caseload from 1407 cases to 1192 cases, a 18% reduction.[6] In addition, OIG reduced the number of cases that had been open over 60 days, from 1,042 to 766, or 26.4%. The below tables reflects the number of cases OIG opened and closed from FY19 through FY21.[7]

[6] The Bureau caseload figures set forth below do not include open death reviews whereas the opened and closed case figures do include completed death reviews.

[7] The June 30, 2020 Caseload figures are, in some cases, slightly different from those reported in OIG's FY20 Annual Report, likely due to database reclassifications or corrections that occurred during FY21.



FY20 and FY21 Caseload Comparison By Bureau		
	Caseload as of June 30, 2020	**Caseload as of June 30, 2021**
Central	136	208
Cook	329	235
Metro	576	387
North	107	139
South	259	223
OIG	**1407**	**1192**

With respect to OIG's Metro Bureau specifically, OIG noted in the FY20 annual report that its hiring of additional personnel, including a second Investigative Team Leader, would likely result in a decreased caseload at Metro. This prediction proved correct: with those additional resources and through the efforts of Metro's dedicated staff, the bureau reduced its caseload from 576 to 387, a reduction of over 30 percent.

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 interviews of numerous staff and individuals, theissuance 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 not always possible.

In addition, although OIG has reduced its overall 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. Accordingly, it remains a priority for OIG to keep investigator caseloads at reasonable levels.

As noted above, in FY21, OIG was able to significantly reduce the number of OIG cases that had been open for more than 60 days. In addition, OIG increased the percentage of cases it completed within 60 days from 47% in FY20 to 50% in FY21.

Cases Completed Within and Over 60 Days FY19 through FY21		
Fiscal Year	**Cases Completed Within 60 Days**	**Cases Completed Over 60 Days**
FY19	**39%**	**61%**
	(1,487)	**(2,371)**
FY20	**47%**	**53%**
	(1,618)	**(1,847)**
FY21	**50%**	**50%**
	(1367)	**(1372)**

As the below table reflects, though, for the past three years, OIG's average time to complete an investigation has remained above sixty days.[8] OIG further notes that the average time it took to complete a case increased from 118.7 days to 129.24, which is largely due to OIG's increased focus on completing the oldest of its cases (when OIG completes more older cases, that produces long-term productivity gains, as noted above, but, in the short term, serves to raise OIG's average time of case

[8] 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 and the criminal process is complete. 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 the criminal process. For this reason, OIG counts "average total days" and "average OIG days" separately.

completion). OIG expects that as the Office continues to reduce the number of cases overall, and in particular the number of older cases, the average days for case completion will begin to decline again.

FY19 through FY21 – Average Days for Case Completion		
Year	**Average Total Days**	**Average OIG Days**
FY19	122.3	121.6
FY20	119.4	118.7
FY21	130.93	129.24

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 carestaff. OIG calculates those ratios as of June 30, 2021, or the last day of FY21.

Below are the census figures and staffing ratios for each type of facility at the close of FY21. 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, 2021 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 staffas only a fraction. That count, again as of June 30, 2021, is reflected in the fourth column of the tables.

OIG divides the June 30, 2021 direct care staff figures by the June 30, 2021 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, 2021)					
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	209	37,189	99	169.90	2.00
Chester MHC	455	98,978	281	340.00	1.34
Chicago Read MHC	287	48,815	141	165.50	1.27
Choate MH & DC Total	326	94,214	263	408.20	1.59
Elgin MHC	672	113,729	321	424.30	1.32
Fox DC	81	28,231	75	128.00	1.60
Kiley DC	215	72,016	199	303.80	1.57
Ludeman DC	339	121,509	328	622.00	1.86
Mabley DC	118	40,172	112	163.75	1.50
Madden MHC	1545	35,468	93	154.10	2.08
McFarland MHC	229	44,369	118	161.75	1.32
Murray DC	260	89,333	245	385.82	1.49
Shapiro DC	495	171,965	464	827.77	1.77
Total DD Facilities	**1761**	**617,440**	**1692**	**2,819.24**	**1.67**
Total MH Facilities	**3397**	**378548**	**1053**	**1,423.35**	**1.43**

E. Quality Care Board

The purpose of the Quality Care Board ("QCB" or the "Board"), which was authorized in 1992, isto "monitor and oversee [OIG's] operations, policies and procedures." *See* Department of Human Services Act, 20 ILCS 1305/1-17(u). 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(u). The members must be qualified by professional knowledge or experience in law, investigatory techniques, or the care of people whohave 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 FY21 were:

Brian Dunn, Chairman (Resigned April 13, 2021)
Saul Morse, Chairman (Appointed June 2, 2021)
Angela Hearts-Glass
Megan Norlin
Shirley Perez
Jae Jin Pak

OIG has been working and will continue to work with IDHS and the Governor's Office to appoint additional members to the QCB in order to fulfill the statutory membership requirements.

The QCB held five meetings in FY21, all by teleconference. The meeting dates were as follows:

July 14, 2020
August 11, 2020
October 13, 2020
December 8, 2020
February 9, 2021
April 13, 2021
June 15, 2021

Chapter 4: Areas of Advancement

During FY21, 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.

A. FY20 and FY21 Complaint Intake Pilot Project

Following the successful initiation of OIG's complaint intake pilot project involving the referral of certain allegations to five SOFs, which commenced in FY20 and continued into FY21, OIG expanded the program to additional SOFs. As background, in FY20, in order to ensure that OIG was using its limited investigatory resources in the most efficient and effective manner possible, OIG initiated a pilot project—which it developed in conjunction with DDD, DMH, and several advocacy organizations—wherein OIG's Intake Bureau, with Inspector General approval, referred cases to the State-operated facilities to address situations where: (1) the allegation, if true, would likely not result in a report to the HCWR; (2) another entity was better positioned to immediately address the situation; and/or (3) the reporting entity or person had already identified the primary facts relevant to the allegation, meaning additional investigative work would be of minimal value.

As part of this pilot project, OIG did not refer allegations if they: (i) presented an emergency situation; (ii) indicated that an individual was in imminent danger; or (iii) would likely result in the reporting of an employee to the HCWR.

During the pilot project, OIG made 87 referrals to facilities. Of those, 78 were self-reported allegations. Below are additional FY21 metrics regarding the number of cases OIG referred and the results of those referrals.

FY21 – Average Number of Days to Receive Facility Response[9]		
Disability Type	**# of Cases**	**Average Working Days to Receive Facility Response**
DD	34	10
MH	34	44
Total	68	27

In FY21, facilities imposed administrative discipline in 6 cases, provided re-training in 11 cases and took other non-disciplinary action in 4 cases. OIG conducted compliance reviews of 10 of the 68 approved facility written responses that OIG received in FY21 regarding referrals. OIG did not identify issues with respect to any of those responses.

Going forward, OIG will look to expand the initiative to community agencies as well and will be working with the DD and MH divisions to determine how best to do so.

B. OIG Directive Changes

During FY21, OIG revised its directives to improve investigation timeliness. More specifically, OIG now requires investigators to contact and interview the complainant or required reporter within fifteen days of case assignment, absent extenuating circumstances, in order to verify the information contained in the Intake and ask appropriate follow-up questions. Investigators are also to contact and interview the victim or the victim's guardian within fifteen days, absent extenuating circumstances. OIG expects that these new timeliness requirements should help OIG complete its investigations in a more efficient manner.

C. The Amendment of 405 ILCS 5/3-210

In FY21, OIG proposed an amendment to 405 ILCS 5/3-210, which was subsequently enacted, that was designed to allow IDHS OIG and IDHS to reduce the amount of paid administrative leave at State-operated facilities and improve staffing at State-operated facilities by more quickly returning to work employees who were under investigation in situations where OIG has determined that the allegations against the employee will be unsubstantiated or unfounded in OIG's investigative report.

As background, pursuant to federal regulations, if OIG receives an allegation that three SODC employees physically abused an individual, the SODC will likely place those employees on

[9] The Average Working days to receive the response was based on the date Intake was received in OIG. At the present time, OIG's database does not capture the date OIG sent the referral to the facility, but it is attempting to add this capability. Typically, there are 1 or 2 days between the date OIG receives the Intake and the Referral date.

administrative reassignment pending the results of OIG's investigation. If OIG has not concluded its investigation within 60 days, those employees will likely be placed on paid administrative leave.

Under the former language of 405 ILCS 5/3-210, if OIG determined within the first week of the investigation that one of those employees was on vacation at the time of the alleged abuse, the employee who was on vacation at the time of the alleged abuse still could not be returned to work until OIG's investigation was completed against the other two subjects. Under the amended language, the employee who was on vacation can return to work while OIG's investigation continues regarding the other subjects. Such a return allows the SODC to better staff their facility, avoid putting an employee on paid administrative leave unnecessarily, and poses no danger to the safety or well-being of individuals.

On August 20, 2021, Public Act 102-0501 was signed into law, amending 405 ILCS 5/3-210. The Act will become effective on January 1, 2022.

Chapter 5: Training and Certification Updates

A. Staff Training

The State of Illinois, IDHS, and OIG require OIG staff to take certain training courses. The State of Illinois and IDHS have several annual mandatory trainings that cover topics like HIPAA, and Ethics. OIG's investigative staff are also to receive ongoing training in Title 59, Chapter I, Parts 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 (CILAs), administration of medication in community settings, and minimum standards for certification of developmental training programs, all of which areas 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 FY21, OIG staff completed all courses to meet these requirements.

In FY21, OIG also started the process to convert documenting staff training from the OIG database to the DHS OneNet Training system, which should be completed by the end of FY22.

OIG notes that each of the seven new investigative staff hired in FY21 (four Internal Security Investigators (ISIs), one Investigative Team Leader, one RN Clinical Coordinator and the new Deputy Inspector General) 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, who assists the 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.

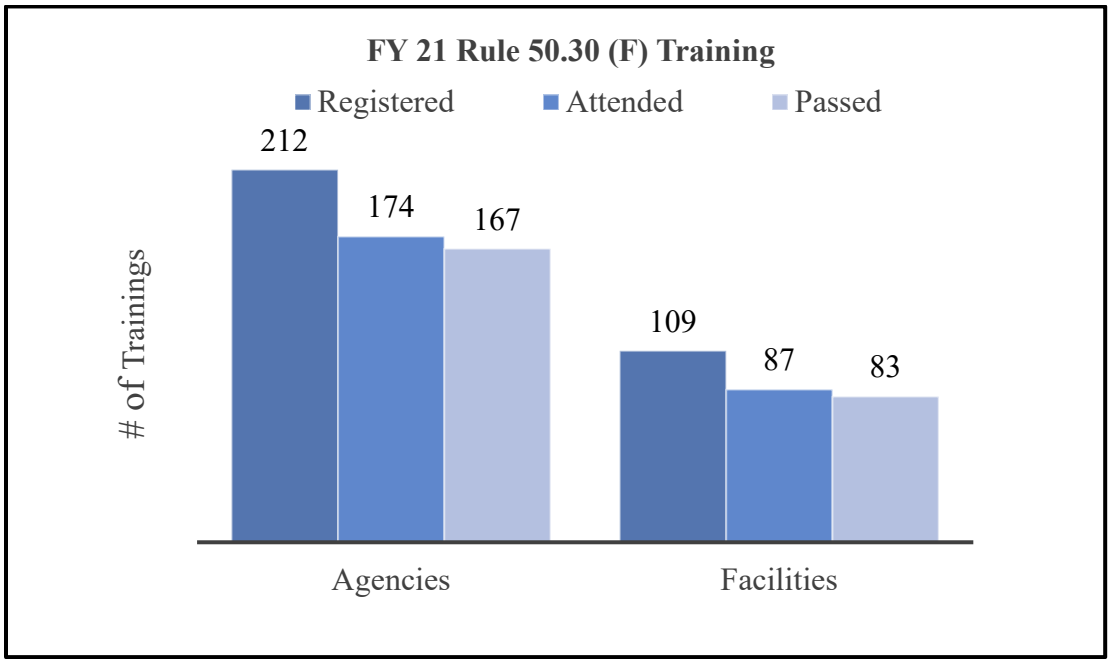
OIG conducts weekly evaluations and written assessments to ensure the new probationary ISIs obtain all necessary investigative skills. Of the four ISIs OIG hired in FY21, all four completed their classroom and field training to become certified ISIs.

B. Training for Agencies and Facilities

50.30(f) Initial Incident Response

Section 50.30(f) of Rule 50 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 statementsfrom 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 FY21, 321 agency and facility staff registered for OIG's online 50.30(f) training, 261 attended the training and 250 completed the training. To complete the training, the staff have to score 70% or better on a test. 96% of agency staff and 95% 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's 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 FY21, 37 facility staff registered for the training and 31 staff completed the training.

OIG Training Updates

In FY21, OIG began a review of its internal training processes, as well as its trainings for agencies and facilities. OIG's goal is to use IDHS's OneNet system to initiate, implement and document such trainings.

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 312 cases OIG substantiated in FY21, reflecting some of the most egregious employee conduct, as well as a brief summary of OIG's investigation of the COVID-19 outbreak at the Illinois Department of Veterans' Affairs' LaSalle Veterans' Home (the "LaSalle Home").

9921-0001 – In October, November, and December of 2020, more than 200 Veterans and staff at the LaSalle Home tested positive for COVID-19, and 36 Veterans died. The Governor subsequently asked OIG to conduct an investigation into the COVID-19 outbreak. OIG retained outside counsel to assist it in investigating the circumstances surrounding the outbreak. As part of its investigation, OIG analyzed COVID-19 data, trends, and protocol in the Home and assessed IDVA's preparation, response, and compliance with protocols and regulations. The investigation included 29 individual interviews and the review of hundreds of documents. Ultimately, OIG's investigation determined that the Illinois Department of Veterans' Affairs' ("IDVA") lack of COVID-19 preparation contributed to the scope of the outbreak at the Home and that failures in communication at the Home and within IDVA leadership contributed to a delayed response to the outbreak. In order to prevent future outbreaks at the LaSalle Home, OIG made nine recommendations to IDVA, including that IDVA create centralized policies at the LaSalle Home and develop outbreak drills and stress tests, develop an infection control task force or committee within the LaSalle Home, and educate LaSalle Home staff on the importance of quality infection control. IDVA accepted all nine of OIG's recommendations.

6620-0092 – OIG substantiated a finding of physical abuse where its investigation established that an employee inappropriately, and without justification, forcibly slammed an individual to the ground. OIG further recommended the facility take appropriate administrative action with respect to four other employee witnesses who provided OIG with a materially false narrative that exaggerated the threat posed by the individual. That all four witnesses recited the same lie strongly suggested that they were working in coordination. Accordingly, their statements were indicative of a "code of silence" wherein employees attempted to cover up their colleagues' misconduct by providing false testimony. Had the video evidence not existed, the false testimony may have allowed the employee to avoid responsibility for their abusive conduct. With respect to the administrative process, after OIG completed its investigation, the employee filed an appeal

regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending. With respect to the four witnesses who provided false narratives to OIG, three served a 7-day suspension and the fourth separated from the facility prior to the completion of the disciplinary process.

6621-0033 - OIG substantiated a finding of physical abuse where its investigation established that an employee intentionally and inappropriately grabbed an individual from behind, lifted them off the ground, and threw them onto the floor, after the individual cursed at staff and emptied a laundry container into an otherwise empty corridor. OIG further recommended the facility take appropriate administrative action with respect to two other employee witnesses who provided OIG with a materially false narrative in which they exaggerated the threat posed by the individual. Given the similarity of the false statements, those statements were indicative of a code of silence wherein employees attempt to cover-up their colleagues' misconduct by providing false testimony. After OIG completed its investigation, the employee filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending. The two employees who provided a false narrative to OIG served 7-day suspensions.

1021-0144 - OIG substantiated a finding of physical abuse where its investigation established that an employee intentionally and inappropriately shut a door on an individual, resulting in the individual's left foot being stuck under the door frame. After OIG completed its investigation, the employee filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

1121-0017 - OIG substantiated a finding of neglect where its investigation established that, for a period of several months in 2019 and 2020, three employees failed to administer three individuals' prescribed medications, which failure increased the individuals' risks for medical complications, misdiagnoses, and maladaptive behaviors. OIG's investigation further established that the three employees falsified Medical Administration Records to indicate that they had administered the medications. In addition, OIG substantiated a finding of neglect regarding the home manager, who failed to appropriately supervise the CILA home in multiple ways, including failing to ensure appropriate staff were scheduled to work one weekend. OIG's investigation also established a finding of neglect regarding the agency, due to the collective and systemic failure of the agency's staff to adequately care for the CILA home individuals over a period of months. The four employees were terminated prior to the completion of OIG's investigation.

1818-0029 – OIG substantiated a finding of financial exploitation where the employee who was responsible for oversight of individuals' trust funds, processed a fraudulent trust fund withdrawal from an individual's account in the amount of $800 and disbursed it to themself. The employee then attempted to cover up the transaction by processing an invoice estimate from a furniture store as if it were a receipt and provided a false narrative regarding the incident. The employee was ultimately charged criminally with theft and official misconduct and entered an Offender Initiative Program. After OIG completed its investigation, the employee filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

1016-0346 – OIG substantiated a finding of egregious neglect regarding an employee who failed to make a required water temperature check when giving an individual a shower and left the individual unattended in the shower with the water on for an unknown amount of time, which, due to high water temperatures, caused second degree burns to approximately 27% of the individual's body. In addition, the employee failed to seek emergency medical treatment for the individual after observing their injuries and waited at least 20 minutes to call the nurse on duty. Following a criminal investigation, the employee pleaded guilty to one count of Neglect of a Person with a Disability by a Caregiver and was sentenced to two years of probation. OIG also substantiated a finding of neglect based on the nurse's violation of agency policy as the evidence established that they failed to immediately notify their supervisor of the individual's change in medical condition once they learned of that change from the employee. With respect to the administrative process, after OIG completed its investigation, the employee filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

3920-0046 - OIG substantiated a finding of physical abuse where its investigation established that an employee slapped an individual and attempted to drag the individual across the floor. OIG reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

5420-0030 - OIG substantiated a finding of physical abuse where its investigation established that an employee tackled an individual, forcefully making contact with the individual's shoulder, causing the individual to fall to the ground. The individual subsequently reported pain to their left arm, leg, and shoulder. OIG reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1620-0342 - OIG substantiated a finding of physical abuse where its investigation established that an employee struck an individual over the head with a chair, resulting in a cut to their head. OIG reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1620-0123 - OIG substantiated a finding of physical abuse where its investigation established that an employee used unauthorized restraint techniques on an individual. More specifically, the employee used a chokehold while on top of the individual with their knees on the individual's ankle. The individual sustained bruising to their arms and torso. With respect to the administrative process, after OIG completed its investigation, the employee filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

1620-0231 – OIG substantiated a finding of egregious neglect where its investigation established that an employee failed to provide a high-risk individual with adequate personal care and maintenance related to skin issues, resulting in an open wound on their right leg. The employee did not seek medical attention for the wound and did not notify the agency about the wound prior to the agency's independent discovery of it. The individual required two inpatient hospitalizations and ongoing wound care. After OIG completed its investigation, the employee filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting

would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

1221-0278 – OIG substantiated a finding of physical abuse where its investigation established that an employee intentionally and inappropriately placed an individual into a headlock after the individual became physically aggressive with the employee. OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1221-0355 – OIG substantiated a finding of sexual abuse when its investigation established that an employee engaged in consensual sexual intercourse with an individual in their apartment during the employee's shift. OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1319-0253 - OIG substantiated a finding of physical abuse where its investigation established that an employee intentionally and inappropriately grabbed, pushed, tripped, and dragged an individual. Following a criminal investigation of the employee's actions, the employee pleaded guilty to one count of misdemeanor battery. OIG also substantiated neglect findings regarding two other employees who stood by and watched the altercation but did not intervene. OIG subsequently reported the name of the employee who engaged in physical abuse and OIG's physical abuse finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1321-0023 – OIG substantiated a finding of physical abuse where its investigation established that an employee intentionally and inappropriately punched an individual in the chest and stomach when they were frustrated that an individual would not take their medication. OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1320-0275 - OIG substantiated a finding of physical abuse where its investigation established that an employee intentionally and inappropriately struck and repeatedly kicked an individual in the stomach while attempting to get their phone charger from the individual. OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

2921-0096 - OIG substantiated a finding of physical abuse where its investigation established that an employee intentionally and inappropriately grabbed an individual by their throat and threw them to the ground. After OIG completed its investigation, the employee filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

5820-0056 - OIG substantiated a finding of physical abuse where its investigation established that an employee intentionally and inappropriately pulled an individual's hair until the individual released their grip on another individual's hair. OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

2921-0157 – OIG substantiated a finding of neglect where its investigation established that an individual removed two screws out of a bathroom divider wall and ingested one of the screws. During the month prior to this incident, this same individual successfully ingested 4 foreign bodies. Although this individual displayed continuous PICA behavior, the individual was placed on a type of visual observation which allowed a degree of privacy when using the bathroom which allowed them to swallow the screw. In addition, the employee who performed the visual observation failed to remain inside the bathroom's outer door. Staff were subsequently retrained, and the individual's supervision level was reviewed.

2920-0036 – OIG substantiated a finding of neglect where its investigation established that a registered nurse failed to provide adequate medical care to an individual when they failed to obtain immediate medical attention for an individual suffering from respiratory distress who subsequently died.

1320-0349 – OIG substantiated a finding of financial exploitation where its investigation established that an employee, by their own admission, stole various personal items belonging to multiple individuals while working an overnight shift. OIG reported the employee's name and

OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

Chapter 7: IG's Closing Remarks

The metrics set forth in this report reflect that, on a day-to-day basis, OIG is making material improvements in terms of its investigative operations. However, a successful organization must also have a long-term vision to ensure the continued execution of its mission. On that front, I am pleased to report that OIG has made progress with respect to certain of the structural challenges I identified in last year's annual report. More specifically, I had noted that OIG did not have any in-house staff with expertise or specific training in budgetary matters or whose position was devoted to the strategic assessment of OIG's financial resources. Accordingly, OIG worked with the appropriate stakeholders to create and post a Chief Administrative Officer (CAO) position in FY21. Although OIG does not expect to fill the position until the 2022 calendar year, once the CAO is hired, OIG believes it will be able to make more strategic use of its budget and technological resources. Such staffing will also likely provide OIG with added independence from IDHS, an important attribute of any watchdog, as OIG will no longer be as reliant on IDHS for resources.

On the theme of OIG independence, OIG also plans to propose legislation that would provide OIG with a statutory budgetary floor. A passage from a 2013 report produced by Business and Professional People for the Public Interest, titled "Inspectors General and Government Corruption: A Guide to Best Practices and an Assessment of Five Illinois Offices," illustrates why a budgetary floor is so important for OIG:

> Control over resources such as budget and staff is a critical aspect of independence, for whoever controls the budget and staff of an OIG can thwart not only individual investigations but an OIG's basic ability to perform its mission . . . . To avoid rendering the OIG vulnerable to changes in executive and legislative leadership, an

> OIG budget floor can be set as a fixed percentage of the overall budget. (For example, the New Orleans OIG budget is set at no less than 0.75 percent of the City operating budget. The Miami-Dade County OIG budget is in part a percentage of all county contracts the OIG audits, inspects, or reviews). In addition to protecting an OIG from interference, such measures also ensure adequate funding. The concern that the OIG budget should be flexibly responsive to current needs can be addressed by other means, for example, by empowering the legislature to raise or lower the OIG budget in emergencies.

The Association of Inspectors General's "Principles and Standards for Offices of Inspector General" similarly state 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."

At the present time, unlike the City of Chicago OIG or the Office of the Illinois Toll Highway Inspector General, OIG does not have a statutory budgetary floor. *See* 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"). Accordingly, as it stands, OIG's budget could potentially be reduced in the General Assembly's and Governor's budget process for any reason or no reason. Therefore, to address this concern and fully establish OIG's independent oversight, in FY22, OIG plans to work with IDHS's legislative team to craft statutory language that provides OIG with such a budget floor.

With respect to the examination and assessment of OIG's internal processes, OIG notes that the Office had engaged the Association of Inspectors General (AIG) to perform the first peer review of OIG in May 2020, which review would have appraised OIG's performance in achieving the investigative standards set forth by the 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 potential improvement, as OIG is committed to being the best investigative body it can be.

In conclusion, as I look to FY22, I am hopeful that the operational limitations OIG has experienced as a result of COVID-19 will lessen and that the Office will be able to transition from the perseverance mindset that it has adopted since March 2020 to a more sustainable approach. OIG is further optimistic that the Office will be able to integrate the remote investigative skills it has honed over the past 18 months into its method of operations to perform at an even higher level. No matter the circumstances, though, let there be no doubt that OIG will be fully dedicated to protecting the vulnerable populations that OIG serves.

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 DisabilitiesAdministrative 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 WorkerRegistry 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 supportagency licensed or certified by a State agency other than the Department, unless operated by theDepartment 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 anindividual'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, sexualconduct, 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 eitheran 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."

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Programs, activities and employment opportunities in the Illinois Department of Human Services are open and accessible to any individual or group without regard to age, sex, race, sexual orientation, disability, ethnic origin or religion. The department is an equal opportunity employer and practices affirmative action and reasonable accommodation programs.

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