State of Illinois
Department of Human Services

Abuse and Neglect of Adults with Disabilities

IDHS Office of the Inspector General
Annual Report FY19

Illinois Department of Human Services
JB Pritzker, Governor • Grace B. Hou, Secretary

December 16, 2019

To Governor Pritzker and Members of the Illinois General Assembly:

2019 was a year of transition for the Illinois Department of Human Services Office of the Inspector General (OIG). Following the end of Michael J. McCotter's tenure as Inspector General in May 2019, Daniel Dyslin served ably as Acting Inspector General until I was appointed Inspector General in November 2019.

Throughout the multiple changes in leadership, OIG remained steadfast in its efforts to carry out its statutory mission of investigating and reporting allegations concerning the abuse and neglect of adults who have disabilities, or who reside in state-operated Mental Health and Developmental Disability facilities or in programs operated by local community agencies that are licensed, certified or funded by DHS to provide mental health or developmental disability services.

In fact, OIG, as reflected in the attached Fiscal Year (FY) 2019 report, submitted in accordance with the Illinois Department of Human Services Act (20 ILCS 1305/1-17), showed improvement with respect to multiple metrics in FY2019, including closing almost 10 percent more abuse and neglect investigations in FY2019 than FY2018.

To continue moving in a positive direction in FY2020, OIG will, among other efforts: (1) conduct a thorough examination of its policies and procedures to ensure OIG is operating in accord with investigative best practices; and (2) seek to engage with outside experts and consultants to identify additional potential efficiency gains.

As always, OIG remains committed to preventing and detecting the abuse and neglect of Illinois residents who are facing mental and physical challenges.

Sincerely,

Peter B. Neumer
Acting Inspector General

Executive Summary

During FY2019, the Office of the Inspector General (OIG):

- Closed 3,729 investigations into abuse or neglect allegations, an increase of 9.8% over FY2018. OIG substantiated abuse or neglect in 300 of those investigations, including 252 (84%) community agency cases and 48 (16%) facility cases.

- Received 8,623 phone contacts through the OIG Hotline, a slight increase over FY2018.

- Received 3,578 abuse or neglect allegations, a decrease of 7.6% from FY2018, including 10.1% fewer allegations at community agencies and 1.6% fewer allegations at facilities.

- Received 196 reports of deaths of individuals who were, or had been, receiving services in facility or community agency programs.

- Referred 1,508 complaints that were outside OIG's jurisdiction to the appropriate entities for follow up.

- Referred 48 employees of facilities or community agencies to the Illinois Department of Public Health's (IDPH) Health Care Worker Registry (HCWR) for substantiated physical abuse, sexual abuse, financial exploitation, or egregious neglect.

- Closed 236 death cases. OIG substantiated neglect in 14 of those cases and identified issues in 43 of the other cases.

- Recommended administrative action in 1,072 cases at facilities or community agencies. OIG received DHS-approved written responses in 942 of those cases, as well as another 112 completed from prior years, for a total of 1,054 written responses. OIG identified a total of 1,550 issues, the most common being substantiated neglect and late reporting to OIG.

- Presented OIG Investigative Steps training to 58 facility staff members by e-mailing a narrated PowerPoint, resulting in the certification of all 58 staff members; OIG also emailed a Rule 50.30(f) training PowerPoint to 336 facility and community agency staff (an increase of 10.5% over FY2018) resulting in the certification of 272 staff members.

- Conducted unannounced site visits to all fourteen DHS facilities providing mental health or developmental disability services and made 74 recommendations to the facilities.

- Hired six new investigators, two of whom left during the initial training period. With retirements, OIG had 31 investigators at the end of FY2019.

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Chapter 1: Preventing Abuse and Neglect

A. Quality Care Board

The Quality Care Board was authorized in 1992 by Public Act 87-1158, which states that the Board's purpose is to "monitor and oversee the operations, policies and procedures" of the Office of the Inspector General. The board is empowered to provide consultation on OIG practices, to review regulations, to advise on training, and to recommend policies to improve intergovernmental relations.

The law provides for the Board to have seven members, each appointed by the Governor with consent of the State Senate. 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 for travel.
The Quality Care Board members for most of FY2019 were:

David Friedland, Chair, Wheaton, Illinois
Dr. John Pingo, Loves Park, IL
Cathy Lomasney, Homer Glen, IL
Merlin Lehman, Bloomington, IL
Katherine Burson, Darien, IL

Three quarterly Board meetings were held in in FY2019: July 11, 2018, November 9, 2018, and April 26, 2019; all via teleconference.

Appointments for the above members were withdrawn on May 20, 2019. As of the end of FY2019, no replacements have been named. (NOTE: Four replacement Board members were nominated on October 18, 2019, and one on November 8, 2019.)

B. Unannounced Site Visits

As part of its statutory mission to prevent abuse and neglect (20 ILCS 1305/1-17), OIG conducts annual unannounced site visits to the DHS facilities that provide developmental disability or mental health services.

The site visits seek to cover a wide range of activities, initiatives, and potential problem areas related to abuse and neglect. Each year, OIG identifies issues and provides constructive feedback to the facilities that allows them to take steps to reduce instances of abuse and neglect.

FY2019 Site Visits

OIG's site visit protocol was created on January 16, 1997. In addition to addressing recommendations from FY2018, the site visit protocol for FY2019 included a review of the following:

Facility Implementation of Sepsis/Septic Shock Program Directives

- Facility Policy
- Training of staff on requirements and criteria/testing for competency
- Prevention measures

Facility Reporting to OIG Hotline
- Internal procedures
- Screening, delays or other issues in reporting allegations to the Hotline
- Special internal procedures for weekend or other calls requiring immediate action

MH Facility Administration of Psychotropic Medication
- Compliance with Program Directive 02.06.02.020
- Obtaining Consent for the Administration of Psychotropic Medication
- Refusal of Treatment, Non-Emergency Situations
- Refusal of Treatment, Emergency Situations, First 72 Hours
- Petition for Administration of Authorized Involuntary Treatment
- Treatment Review Committee

Informed Consent for Physical and Dental Examination

Transition from Facilities to Community (DD facilities)
- Continuity of Care

Site Visit Dates

In FY2019, the dates of the site visits were as follows:

Alton Mental Health Center	March 6 & 26, 2019
Chester Mental Health Center	February 6 - 7, 2019
Chicago-Read Mental Health Center	May 8 - 9, 2019
Choate Developmental Center	March 20 & April 26, 2019
Choate Mental Health Center	March 20 & April 26, 2019
Elgin Mental Health Center	May 22 - 23, 2019
Fox Developmental Center	October 17, 2018
Kiley Developmental Center	April 24 - 25, 2019
Ludeman Developmental Center	February 27 & March 18, 2019
Mabley Developmental Center	June 12 - 13, 2019
Madden Mental Health Center	October 3 - 4, 2018
McFarland Mental Health Center	November 14-15, 2018
Murray Developmental Center	June 12, 2019
Shapiro Developmental Center	June 18 & 25, 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. After a document review, site visitors then went to each facility and had an entrance conference with the facility's administrative staff. OIG's site visitors introduced themselves, provided an explanation of the site visit plan, identified the staff to be interviewed, and requested any needed records. The OIG site visit team then reviewed the relevant documentation and interviewed appropriate personnel to discuss the topics of review and observe processes. Following the on-site portion of the review, site visitors did additional work, analyzing data and clarifying any outstanding matters. Each site visit ended with an exit conference, where OIG presented its findings. OIG also provided each facility with a formal report within sixty working days after the completion of its site visit follow-up.

OIG asked each facility to submit to OIG a written plan to address the report's recommendations within sixty days of the site visit's completion. Receiving this written plan assists OIG in planning the next year's site visits, as OIG follows up on the facility's actions in response to recommendations made the prior year. It also greatly reduces repeat recommendations for the upcoming year.

In FY2019, OIG made 74 recommendations, an increase of 18 from FY2018. Second-year follow up issues from FY2018 mainly included documentation issues (Treatment Plans, proper/updated forms, environmental survey forms). However, there were significant recommendations relating to initial facility investigative (Rule 50.30(f)) steps, including four second-year recommendations for either not using or under-utilizing facility staff who were already trained to perform investigatory functions and for lacking trained staff other than security or Security Therapy Aide (STA) staff to perform those functions. At one facility, site visitors found that security staff were not always separating witnesses at the time of the initial allegation, which could result in compromised investigations.

OIG also found the following:

Sepsis/Septic Shock Program Directives

Overall, all fourteen state-operated facilities did a great job of rolling out the new sepsis-related program directives, training their staff, and ensuring staff were familiar with requirements. In FY2019, OIG made nine recommendations at DD facilities and three at MH facilities. Documentation issues at four facilities (three DD and one MH) included lack of guardian notification upon hospitalization for sepsis-related reasons, no guardian signature on Special Team Meeting forms, and improper monitoring individuals, post-hospitalization. Five facilities (three DD and one MH) did not complete annual sepsis training as required or had staff that were not familiar with sepsis and the program directives relating to facility requirements. Two DD facilities did not have a required Special Team Meeting following hospitalization of individuals and one DD facility did not have a Sepsis policy.

Facility Reporting to OIG Hotline

All facilities have a written policy/procedure directive for reporting to OIG and investigating abuse, neglect, and exploitation. However, there is no consistent policy for reporting across facilities. Despite the differences, OIG observed that all facilities appeared to be following their written policies and procedures and meeting OIG reporting requirements.

OIG found that there was no direct patient access to telephones at half (7/14) of the facilities. The facilities reported that if an individual makes a request to use the phone, access is granted. This generally involves revealing the nature of the phone call which violates patient's rights to unimpeded communication with OIG. OIG noted that patient privacy protections during OIG phone calls was problematic. Most facilities follow a chain of command process for reporting abuse/neglect/exploitation which creates the potential for screening and delays of reporting.

OIG found that fifty percent (7/14) of the facilities did not have staff trained to conduct Rule 50.30(f) investigative steps. The facilities that did have trained staff universally underutilized those employees.

Patient/Family Handbooks, which provide information regarding patient rights and privacy protections, were available at seventy-two percent (10/14) of the facilities. Twenty-eight percent

(4/14) of the facilities failed to include any information regarding protection from abuse/neglect/exploitation and how to report abuse/neglect/exploitation.

OIG reviewed a sample of Non-Reportable (NR) case reports, which require internal facility investigation. Seventy-two percent (10/14) of the facilities demonstrated that they conducted complete and thorough internal investigations. These facilities properly maintained and secured their case files. Twenty-eight percent (4/14) of the facilities either did not complete a follow-up investigation, failed to maintain a file, or completed only a partial investigation.

Administration of Psychotropic Medications

Site visitors examined the seven state operated mental health facilities' compliance with Program Directive 02.06.02.020, Administration of Psychotropic Medication. OIG's review covered important issues such as emergency medication administration, informed consent, and treatment reviews. With respect to emergency medication, medication cannot be administered for a period in excess of 72 hours (excluding Saturdays, Sundays and holidays) unless a Petition for the Administration of Authorized Involuntary Treatment is filed with the court pursuant to the Mental Health and Developmental Disabilities Code, 405 ILCS 5/2-107.

Interviews of medical staff revealed a belief that a one-time dose of emergency medications would not count toward the seventy-two hour period but rather that the administration of medication would only count towards the seventy-two hour period if it was administered on a 24-hour basis. Site visitors reviewed five case files at each facility related to this issue. At one facility, three of five files reviewed revealed facility staff administered emergency medication beyond the seventy-two hour period without a court-filed petition. Three facilities had one of five files where a petition was not timely filed. The three remaining mental health facilities were in compliance with the emergency medication requirements.

As a result of the site visitor's observations on this issue, on January 8, 2018, the Acting Statewide Mental Health Medical Director distributed a memorandum to all mental health hospital administrators and medical directors clarifying that Section 2-107 of the MHDD Code applies when any emergency medication is prescribed to a patient for three consecutive days, irrespective of the frequency of dosing or type of psychotropic medication prescribed.

With few exceptions, the facilities were in compliance with informed consent and treatment review requirements.

C. Training

Internal OIG Training

OIG Directives require that each staff member with investigative credentials must take at least three classes during the fiscal year.

In FY2019, OIG concentrated on investigative techniques and held in-person classes for all investigative staff in Interviewing Skills, Caseload Management, Case Management, and Investigative Skills. OIG also mandated repeat reviews of Rule 50, Rule 115, Rule 116, and Rule 119 PowerPoints for all investigative staff.

External OIG Training

During FY2019, OIG again implemented alternative ways to deliver mandated training other than in-person training sessions. The following sections detail the various types of training and how OIG delivered them.

Rule 50

Up until FY2016, OIG provided in-person training on Rule 50, normally in conjunction with investigative training. On January 1, 2016, when the Community Agency Protocol was eliminated, this type of training was discontinued in favor of a web-based PowerPoint presentation accessible by both facility and community agency staff. This presentation is maintained and kept current by OIG staff. It can be accessed at http://www.dhs.state.il.us/page.aspx?item=33337

Rule 50.30(f)

Rule 50, Section 30(f) mandates that every facility and community agency must have at least one person on staff that has been trained in the OIG-approved methods to preserve evidence for initial incident response and for whom there is no conflict of interest. Upon request, this training is sent out to those agency and facility staff members who have not had a substantiated finding of abuse or neglect within the past three years. The training consists of a PowerPoint presentation on the skills required under 50.30(f), as well as a short post-test to promote competency. Upon receipt of a passing grade on their test, the staff member is considered authorized to perform these duties. This authorization is good for two years, after which the class must be re-taken.

During FY2019, OIG emailed Rule 50.30(f) trainings to 336 facility and community agency staff, an increase of 10.5% over FY2018, resulting in 272 new approved facility or community agency investigators.

OIG Investigative Steps

While OIG has discontinued the Community Agency Investigative Protocol, the Facility Investigative Protocol is still in effect which requires facility investigators to conduct an initial interview of the subject. OIG developed the OIG Investigative Steps class as a refresher on the techniques in Rule 50.30(f) training along with an interviewing skills component. Completion of Rule 50.30(f) training is considered a pre-requisite for interview training.

During FY2019, OIG presented OIG Investigative Steps training to 58 facility staff members via e-mailed narrated PowerPoint presentation. All 58 staff members received certification.

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 direct care staff to those individuals. OIG has always presented that ratio as of June 30, which is the last day of each fiscal year.

Table 1 below shows the census figures and ratios for each type of facility for FY2019. The tables present census figures three ways:

- Counting every individual once, regardless of the number of times he or she is admitted during the year, which gives an "unduplicated count". This count is in the first column.
- A more detailed method is to count every day that those individuals are in the facility or on temporary transfer to another location; this is the "person-days" or "on-books bed-days". This count is given in the second column.
- The third column is the census taken on June 30, 2019; that is, the number of individuals actually in the facility on that day.

OIG used the June 30, 2019 census figure to calculate the direct care staff to patient ratio. 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, 2019, is shown in the fourth column of the tables.

OIG divided the June 30th direct care staff figures by the June 30th census figures to calculate the direct care staff to patient ratio listed in the fifth column.

Table 1: Census and Staffing Ratios, DHS State-Run Facilities, June 30, 2019

DHS Facility	Unduplicated count of individuals served	Person-days *(on-books annual totals)*	Inpatient census on June 30	Direct care staff *(full-time equivalent)*	Direct care to patient ratio
Alton MHC	245	38,191	109	146.60	1.34
Chester MHC	462	98,161	260	335.40	1.29
Chicago-Read MHC	304	49,258	141	177.90	1.26
Choate MHC & DC*	332	83,924	227	413.60	1.82
Elgin MHC	1052	127,510	368	432.60	1.18
Fox DC	94	32,143	84	145.00	1.73
Kiley DC	207	71,192	198	350.30	1.77
Ludeman DC	382	136,110	359	604.00	1.68
Mabley DC	115	39,527	111	164.50	1.48
Madden MHC	1911	32,517	90	136.10	1.51
McFarland MHC	345	49,792	135	152.50	1.13
Murray DC	249	83,850	240	377.82	1.57
Shapiro DC	502	171,525	475	894.97	1.88
DD facility totals	1881	618,271	**1,694**	**2,950.19**	**1.74**
MH facility totals	**4319**	**395,429**	**1,103**	**1,381.10**	**1.25**

Chapter II: Reporting Abuse and Neglect

OIG maintains a 24-hour hotline to receive reports of alleged abuse (which includes financial exploitation) and neglect and respond immediately, if needed. The hotline allows facilities and community agencies to meet the statutory four-hour time frame for reporting.

Facilities and community agencies must report deaths with allegations of abuse/neglect like other allegations of abuse/neglect. With respect to deaths where there is no allegation of abuse/neglect, Rule 50 requires facilities and community agencies to report them to the hotline within 24 hours. This reporting requirement includes any death occurring within 14 days after discharge/transfer, any death occurring within 24 hours after deflection from a residential program or facility, or any death occurring within a residential program or facility or at any department-funded site.

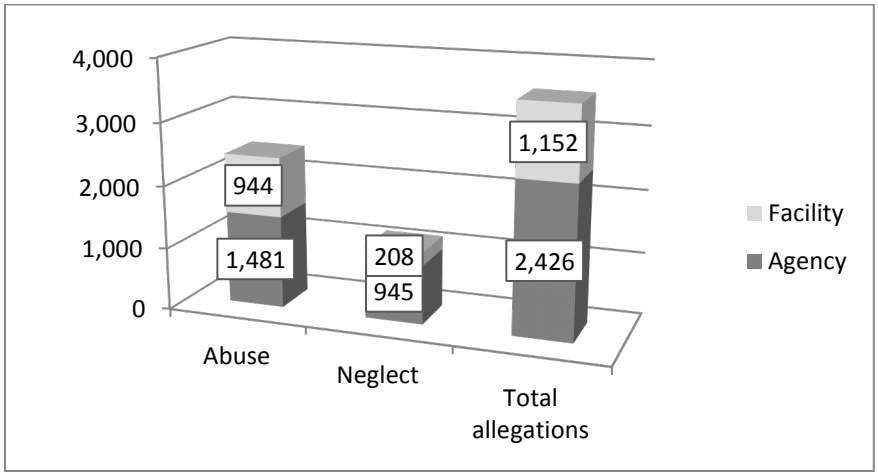
A. FY2019 Reporting

During FY2019, OIG received a total of 3,578 allegations of abuse or neglect. Table 2 below shows the counts by type and location. Financial exploitation is included in abuse, as defined in Rule 50. Tables 3a and 3b, on the following pages, show a more detailed breakdown by allegation type and location.

Table 2: Summary of Allegations Received by OIG in FY2019

	Abuse allegations	**Neglect allegations**	**Total allegations**
DHS-Operated Facilities	944	208	1,152
Community Agencies	1,481	945	2,426
Total	**2,425**	**1,153**	**3,578**

* Contains 32 financial exploitation allegations from DHS-operated facilities and 145 f r o m community agencies.



Total abuse allegations in DHS-operated facilities and community agencies decreased in FY2019 (2,425 versus 2,510 in FY2018), reversing the upward trends seen in FY2017 and FY2018. In

these same settings, allegations of financial exploitation (a subset of abuse) increased by 2.9% over FY2018.

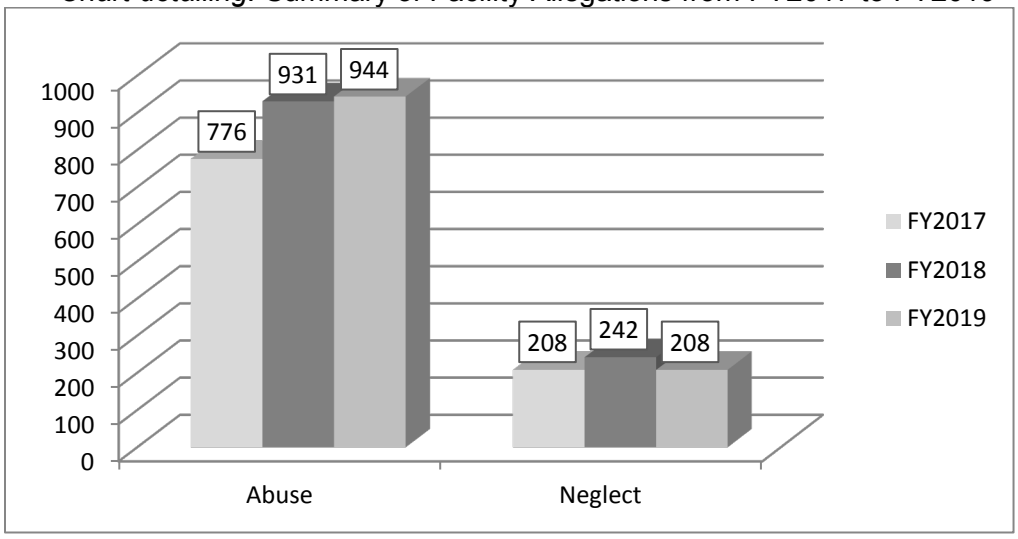
Likewise, total neglect allegations in DHS-operated facilities and community agencies decreased by 15.5% from FY2018.

Facilities

During FY2019, OIG received 1,152 total allegations of abuse and neglect at the DHS-operated facilities, a 1.7% decrease in allegations from FY2018, including 944 allegations of abuse (32 of which were allegations of financial exploitation). Abuse allegations accounted for 82% of the total abuse and neglect allegations at facilities.

OIG also received 208 allegations of neglect at facilities, constituting 18% of the total allegations. The number of neglect allegations decreased by 14.0% over FY2018.

Chart detailing: Summary of Facility Allegations from FY2017 to FY2019



Community Agencies

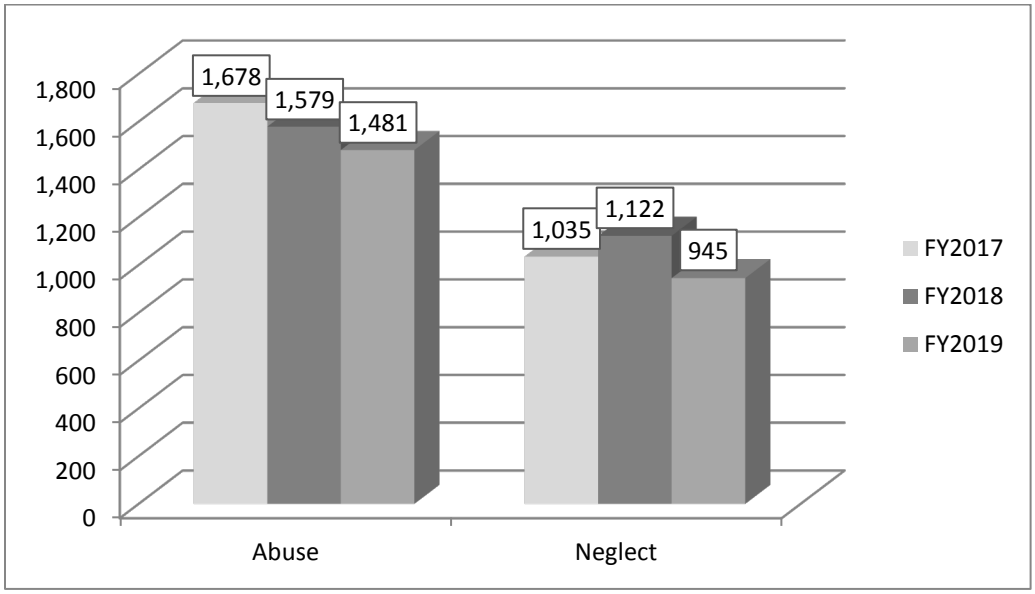
Over the past several years, allegations of abuse or neglect at the community agencies have comprised the majority of total allegations. In FY2019, allegations of abuse and neglect at community agencies accounted for 67.8% of all allegations OIG received. This percentage is reflective of the number of individuals transitioning from institutional care to community agencies under the *Olmstead* decision.[1]

During FY2019, OIG received 2,426 total allegations at community agencies. This is a 10.2% decrease in allegations from FY2018. Of the total allegations, there were 1,481 allegations of abuse, which included 145 allegations of financial exploitation. This year, abuse allegations represented 61.0% of all community agency abuse/neglect allegations. In comparison, FY2018 had a rate of 58.5%, as opposed to 61.8% in FY2017.

[1] For further information, *see*: http://www.dhs.state.il.us/page.aspx?item=98210

OIG also received 945 allegations of neglect at community agencies, a decrease of 15.8% over the 1,122 received during FY2018.

Chart detailing: Summary of Community Agency Allegations from FY2017 to FY2019



Allegation Type

Tables 3a and 3b show the allegations of abuse and neglect and death cases that OIG received during FY2019 by type of allegation and program location. The tables list facilities individually. Where there are "forensic" units (units housing individuals who are committed by a criminal court order), they are differentiated from "civil" units (all others). A subsequent chart shows the proportion of allegations received by each of OIG's five investigative Bureaus.

Allegations and deaths reported by community agencies are grouped into residential programs like community integrated living arrangements (CILAs) and non-residential programs like developmental training (DT) programs.

Deaths

During FY2019, OIG received reports of 196 deaths of individuals who were or had been receiving services in facility or community agency programs, a 9.3% decrease from FY2018. OIG closed 236 death cases during FY2019, a 19.5% increase over the 190 closed during FY2018. Of the 236, OIG substantiated neglect in 14 and found no suspicion of abuse or neglect in the other 222. In 43 of the 222 unsubstantiated cases, OIG identified issues which required a written response from the facility or agency.

Table 3a: Allegations and Deaths Received in FY2019, Mental Health Services Only

Location	Allegations Received						
	Physical abuse	Sexual abuse	Mental abuse	Financial exploita-tion	Neglect	Total received	Death reports
Facilities:							
Alton MHC (*civil*) [1]	19	7	12	0	7	45	0
Alton MHC *(forensic)* [2]	27	8	16	4	2	57	0
Chester MHC[3]	93	6	37	2	22	160	1
Chicago-Read MHC	12	4	9	3	7	35	0
Choate MHC	20	6	14	3	6	49	1
Elgin MHC *(civil)*	18	5	22	4	10	59	3
Elgin MHC *(forensic)*	30	16	28	2	22	98	1
Madden MHC	9	3	16	0	13	41	0
McFarland MHC *(civil)*	25	13	19	2	12	71	1
McFarland MHC *(forensic)*	10	2	7	2	3	24	0
Facility subtotals	**263**	**70**	**180**	**22**	**104**	**639**	**7**
Community agencies:							
Residential	15	6	31	18	17	87	9
Non-Residential	7	9	19	22	14	71	9
Agency subtotals	**22**	**15**	**50**	**40**	**31**	**158**	**18**
Rule 50 MH totals	**285**	**85**	**230**	**62**	**135**	**797**	**25**

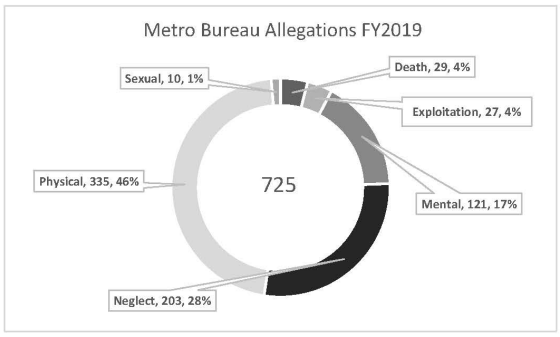
[1] Civil units are for individuals who are not committed to the facility by the criminal judicial system.
[2] Forensic units are for individuals who are criminally court-committed.
[3] Chester is the State's only max-security MH hospital operating under its own legislation.

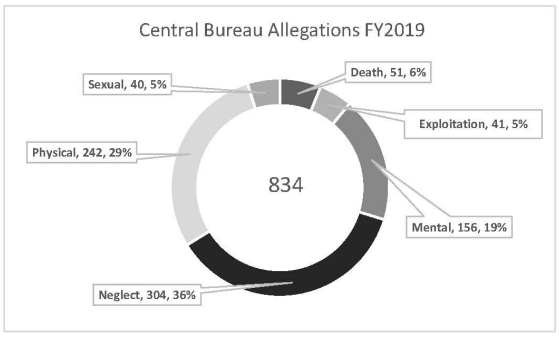
Table 3b: Allegations and Deaths Received in FY2019, Developmental Services Only

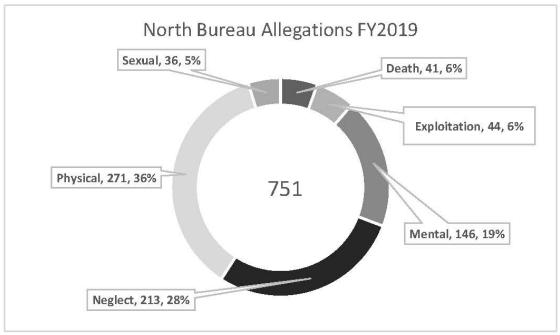
Location	Allegations Received						Death reports
	Physical abuse	Sexual abuse	Mental abuse	Financial exploita-tion	Neglect	Total received	
***Facilities**:*							
Choate DC (*civil)*	72	8	25	1	20	126	1
Choate DC *(forensic)*	0	0	1	0	0	1	0
Fox DC	2	0	0	0	6	8	7
Kiley DC	69	2	11	4	19	105	4
Ludeman DC	47	0	7	1	33	88	5
Mabley DC	28	0	4	2	11	45	3
Murray DC	27	0	6	0	11	44	4
Shapiro DC [1]	75	2	13	2	4	96	7
Facility subtotals	**320**	**12**	**67**	**10**	**104**	**513**	**31**
Community agencies:							
Residential	660	27	286	94	772	1839	136
Non-Residential	161	17	98	11	142	427	4
Agency subtotals	**821**	**44**	**384**	**105**	**914**	**2268**	**140**
Rule 50 DD totals	**1141**	**56**	**451**	**115**	**1018**	**2781**	**171**

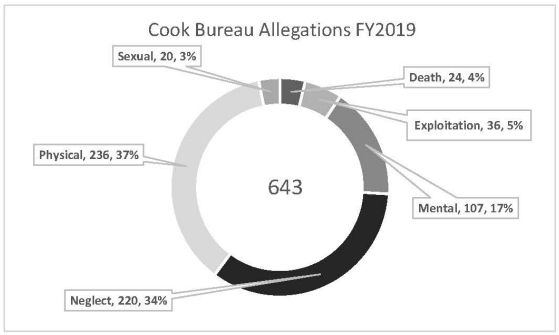
[1] Shapiro is the largest state operated developmental center in Illinois and has the largest geriatric population and the largest population of individuals with high medical needs.

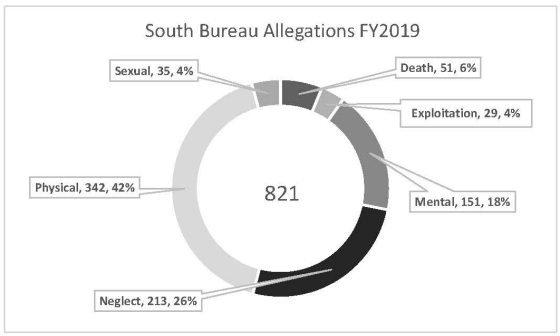
Allegations and Deaths Received in FY2019 by Each of OIG's Five Investigative Bureaus

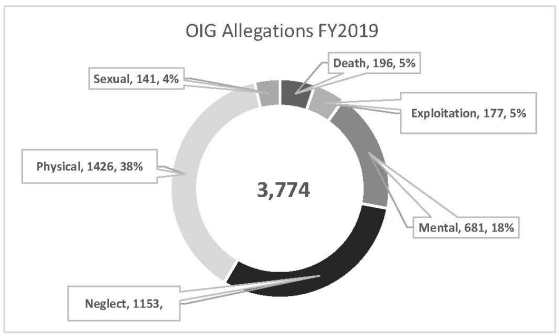












B. Initial Reporting Timeliness

OIG monitors the timeliness of allegations reported to OIG by the staff of the community agency or facility where the alleged abuse or neglect occurred, which OIG refers to as "self-reports". If an allegation is reported late, OIG's database flags it as late reporting. A field investigator then investigates as to why the reporting was late. When OIG issues a final investigative report, it includes this information with a recommendation for correction if the agency or facility was shown to have been late in reporting. The written response would indicate that corrective action is required.

Each month, OIG sends the DHS program divisions a report listing each untimely "self-report". The report includes each late report, the number of days each report was late and the overall percentage of reports that were late. The table below provides this information for the past three fiscal years.

Table 4: Late Reporting by Program and Disability Type, FY2017 through FY2019

Fiscal Year	Total Self-Reports*	Late from Agencies		Late from Facilities		Total Late	Percent Late
		DD	MH	DD	MH		
FY2017	3,195	272	38	22	26	358	11.2
FY2018	2,825	189	28	22	20	259	9.2
FY2019	2,249	170	21	31	18	240	10.7

*Reported to OIG by the facility or community agency itself.

FY2019 shows the continued decrease (20.8% less than FY2018) in self-reports. The trend in late-reporting shows a slight increase from 9.2% in FY2018 to 10.7% late in FY2019.

C. Non-Reportable Complaints

The OIG Hotline receives frequent calls about incidents or complaints that do not meet the abuse or neglect definitions or other reporting requirements in Rule 50. OIG categorizes these calls as non-reportables. With respect to such calls, the hotline investigator explains why the described conduct does not fall within OIG's jurisdiction and, if appropriate, refers or directly transfers the caller to the correct reporting entity.

Referrals

Issues that need follow-up, but are not within OIG's jurisdiction, need to be referred to the most appropriate entity. OIG either makes the referral itself or instructs the caller on where and how to report the allegation.

Frequently, OIG receives calls from a representative of the community agency or facility, self-reporting an issue or incident that is outside of OIG's jurisdiction. In such instances, OIG refers the caller to the appropriate entity and instructs the caller to call OIG back if any indication of abuse or neglect is suspected. Individuals may also call in non-reportable complaints that can be referred to the facility or community agency to address. Referrals were made in 1,436 of the 1,508 (95.2%) non-reportable complaints. Table 5 below shows the referral locations for non-reportable complaints made by OIG this year.

Table 5: Non-Reportable Complaint Referrals Made by OIG in FY2019

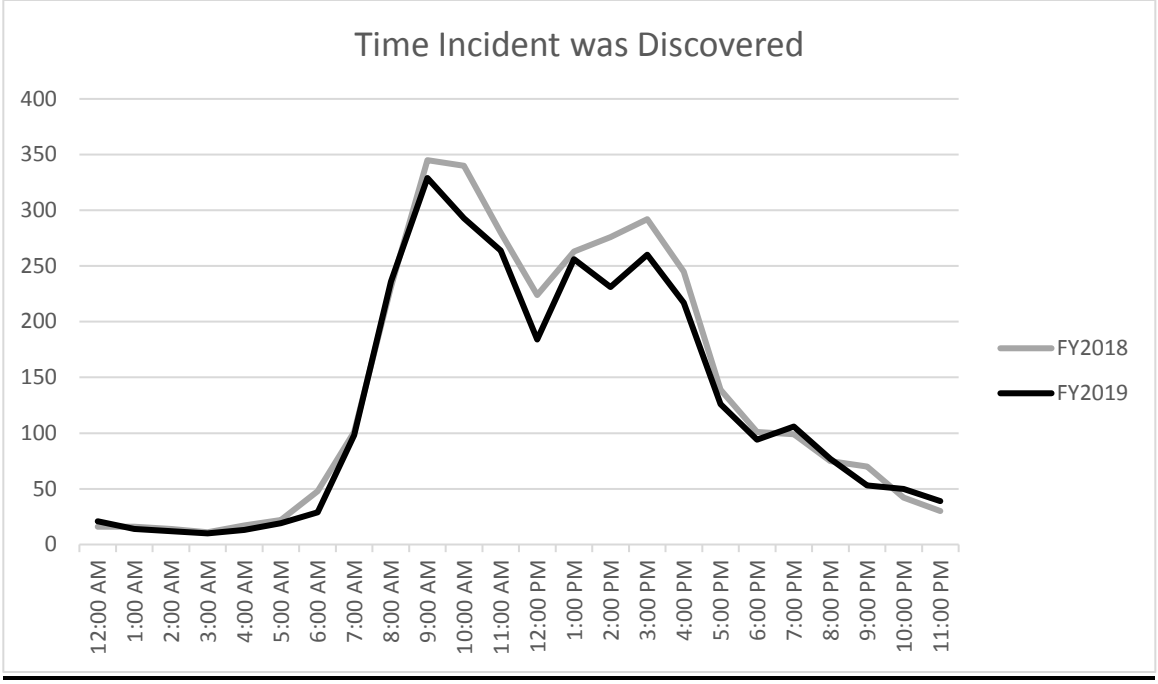
Referral Location	**Count**
Local community agency or facility	1227
Illinois Department of Public Health	3
Department of Health and Family Services	3
Local law enforcement authority	3
Department on Aging	4
DHS – BALC/OCAPS	12
DHS Division of Developmental Disabilities	129
DHS Division of Mental Health	20
Other	35
None needed	72
Total	**1508**

D. Trend Analysis

During the course of an investigation--from initial report to case closure--OIG receives significant amounts of data which it inputs into OIG's Comprehensive Database. While OIG primarily uses this data for the creation of investigative reports and case management, OIG is beginning to analyze this data in the belief that efforts to prevent of abuse and neglect are as important, if not more so, than the *ex post* investigation of incidents. To this end, the following graphs show trends in the reporting and timing of incidents. As OIG delves further into this realm, it will continue to update the graphs and techniques used to better achieve its core objectives.

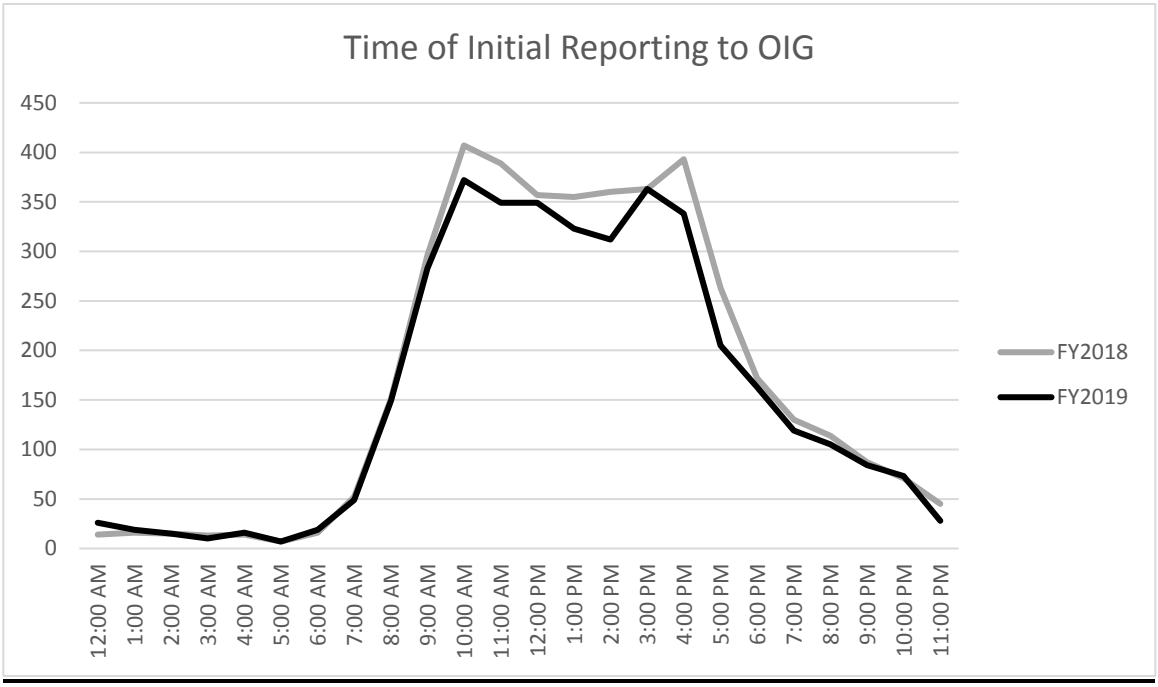
Time of Discovery

The following graph shows the time, if known, that the actual incident was discovered. It does not show incidents where the complainant did not specify the time of discovery. This lack of information can be attributed to the number of allegations made by complainants outside the facility's or community agency's employ.



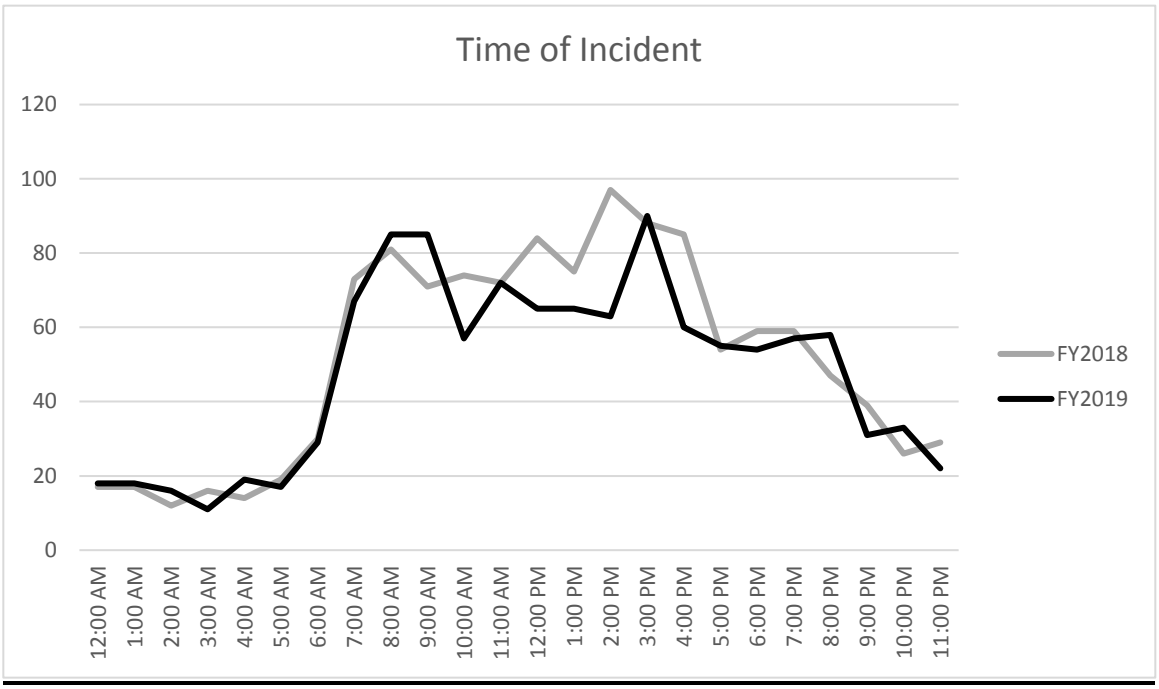
Time of Initial Reporting to OIG

The following graph shows the time that incidents were reported to OIG. OIG uses this graph to make its 24-hour Hotline more responsive to the needs of those reporting allegations of abuse and neglect, as well as deaths of MH/DD service recipients. As can be readily seen, this graph is almost a mirror image of the graph showing Discovery Times. This is directly attributable to the work schedules of facility/community agency staff, as well as the sleeping patterns of the individuals served.



Time of Incident

The following graph shows the times of the incidents as reported to OIG. The graph does not show incidents where the complainant did not specify the incident time. The graph again follows the general shape of the two preceding graphs.



Chapter III: Investigating Abuse and Neglect

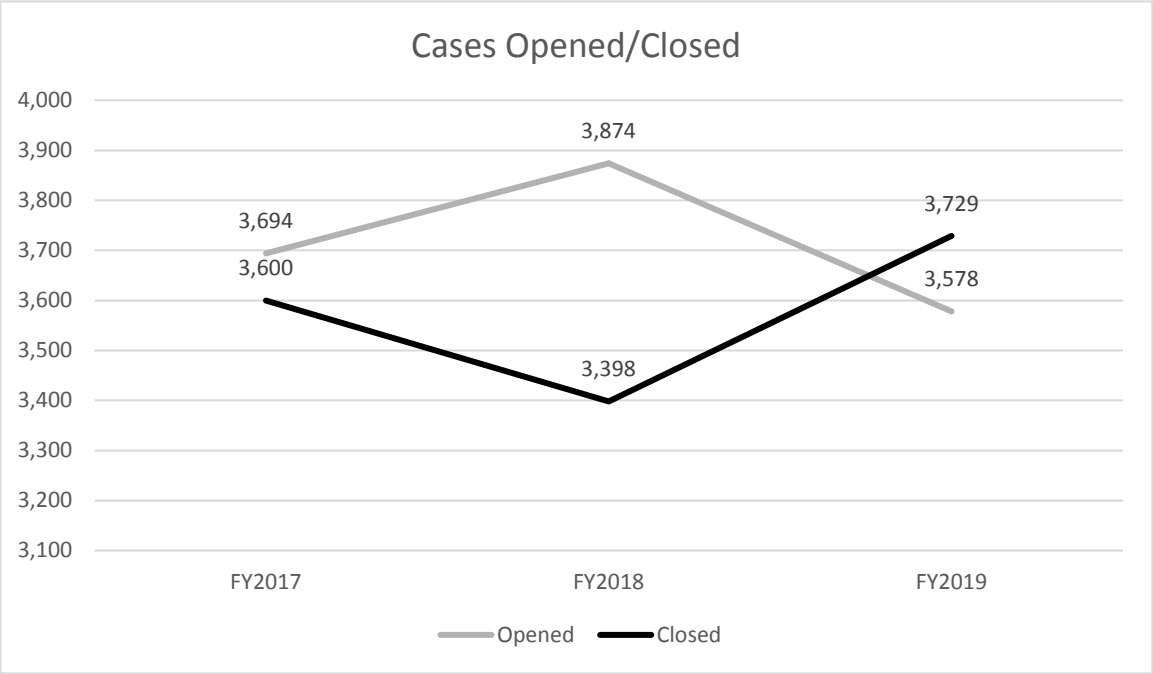
This OIG has the statutory mission of investigating allegations of abuse and neglect of adults with disabilities and who reside in or receive MH/DDD services at facilities or agencies operated, licensed, funded or certified by DHS. OIG is committed to conducting timely and thorough investigations of these allegations and is dedicated to protecting these individuals.

A. FY2019 Case Completions

As noted earlier in this report, the number of investigations opened by OIG, which had steadily increased over the past several years, decreased in FY2019. In FY2019, OIG opened 3,578 abuse/neglect investigations, which is a 7.6% decrease from the previous year. (Death cases are broken out separately.)

During the same fiscal year, OIG closed 3,729 investigations, which is a 9.8% increase over the previous year. In order to continue this positive trend, OIG provided new investigators with additional training, increased supervision, and mentoring. Established investigators are also benefitting from the more hands-on approach of supervisors, coupled with new comprehensive standardized objectives as to the quality and timeliness of investigations.

Chart detailing: FY17-FY19 Opened and Closed Investigations Comparison



B. FY2019 Closures

The findings in abuse or neglect allegations and in death cases OIG closed during FY2019 are presented in the four tables that follow.

Abuse/Neglect Cases

OIG conducts administrative investigations and is bound by the Administrative Code to the "preponderance of evidence" standard. This is defined as "proof sufficient to persuade the finder of fact that a fact sought to be proved is more likely true than not". By law, OIG uses three findings for its case reports:

- "Substantiated", meaning there is a preponderance of evidence;
- "Unsubstantiated", meaning there is credible evidence, but less than a preponderance of evidence to support the allegation; and
- "Unfounded", meaning there is no credible evidence supporting the allegation.

The column entitled "Other issue(s) only" shows cases in which OIG did not substantiate abuse or neglect during an investigation but identified an issue or issues and recommended that the facility or agency take administrative action to address each issue. OIG categorizes these cases as unfounded or unsubstantiated with issues. The column entitled "Not substantiated" shows cases determined to be unfounded or unsubstantiated with no issues.

Table 6a: Abuse/Neglect Cases Closed in FY2019, Mental Health Services Only

Location	Abuse substan-tiated	Exploit. substan-tiated	Neglect substan-tiated	Other issue only	Not substan-tiated	Allegation findings totals
***Facilities**:*						
Alton MHC *(civil)*	2	0	1	4	54	61
Alton MHC *(forensic)*	0	0	0	5	64	69
Chester MHC	5	0	7	7	141	160
Chicago-Read MHC	0	0	0	3	31	34
Choate MHC	0	0	2	8	55	65
Elgin MHC *(civil)*	1	0	0	3	57	61
Elgin MHC *(forensic)*	0	0	1	18	84	103
Madden MHC	1	0	2	6	62	71
McFarland MHC *(civil)*	2	0	0	5	74	81
McFarland MHC *(forensic)*	0	0	0	2	48	50
Facility subtotals	**11**	**0**	**13**	**61**	**670**	**755**
Community agencies:						
Residential	4	0	2	22	79	107
Non-Residential	2	0	3	14	59	78
Agency subtotals	**6**	**0**	**5**	**36**	**138**	**185**
Rule 50 MH Totals	**17**	**0**	**18**	**97**	**808**	**940**

Table 6b: Abuse/Neglect Cases Closed in FY2019, Developmental Services Only

Location	Abuse substan-tiated	Exploit. substan-tiated	Neglect substan-tiated	Other issue only	Not substan - tiated	Allegation findings totals
***Facilities**:*						
Choate DC	3	0	1	17	115	136
Fox DC*	0	0	3	4	8	15
Kiley DC	1	0	1	21	51	74
Ludeman DC	2	0	5	27	53	87
Mabley DC	1	0	0	18	21	40
Murray DC	2	0	4	7	34	47
Shapiro DC	1	0	0	0	85	86
Facility totals	**10**	**0**	**14**	**94**	**367**	**485**
Community agencies:						
Residential	44	13	150	469	1213	1889
Non-Residential	13	0	21	88	293	415
Agency totals	**57**	**13**	**171**	**557**	**1,506**	**2,304**
Rule 50 DD Totals	**67**	**13**	**185**	**651**	**1,873**	**2,789**

* One Fox death case resulted in a finding of unsubstantiated

Death Cases

OIG includes one additional finding when dealing with death investigations, that of "Death Review". OIG uses this finding to designate those deaths that, upon review by OIG Clinical Coordinators, it found to have no indication of abuse or neglect. "Death Review" findings differ from "Not Substantiated" findings in that the latter type of finding takes place after an allegation of abuse or neglect was made or suspected and OIG completes a full investigation.

Table 6c: Death Cases Closed in FY2019, Mental Health Services Only

Location	Abuse substan-tiated	Exploit. substan-tiated	Neglect substan-tiated	Other issue only	Not substan-tiated	Death Review	Totals
Facilities:							
Alton MHC *(civil)* [1]	0	0	0	0	0	0	0
Alton MHC *(forensic)* [2]	0	0	0	0	0	0	0
Chester MHC	0	0	0	0	0	1	1
Chicago-Read MHC	0	0	0	0	0	0	0
Choate MHC	0	0	0	0	0	0	0
Elgin MHC *(civil)*	0	0	0	0	0	3	3
Elgin MHC *(forensic)*	0	0	0	0	0	1	1
Madden MHC	0	0	0	0	0	0	0
McFarland MHC *(civil)*	0	0	0	0	0	1	1
McFarland MHC *(forensic)*	0	0	0	0	0	0	0
Facility subtotals	**0**	**0**	**0**	**0**	**0**	**6**	**6**
Community agencies:							
Residential	0	0	0	3	1	7	11
Non-Residential	0	0	0	0	0	6	6
Agency subtotals	**0**	**0**	**0**	**3**	**1**	**13**	**17**
MH Death Totals	**0**	**0**	**0**	**3**	**1**	**19**	**23**

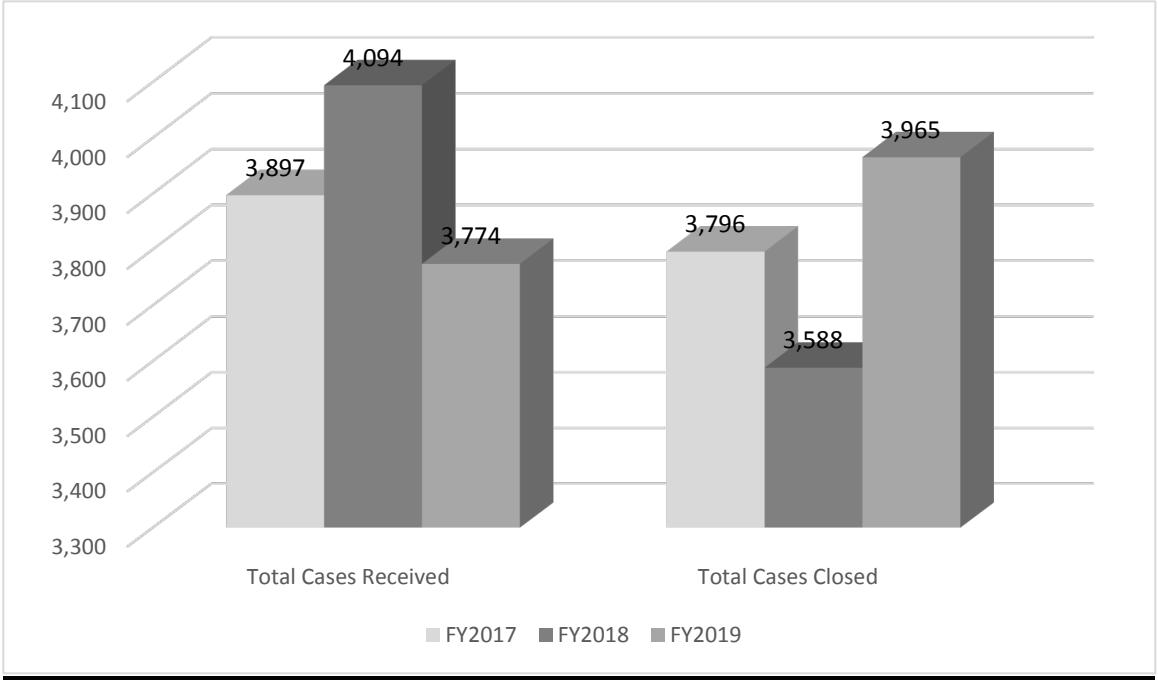
Table 6d: Death Cases Closed in FY2019, Developmental Services Only

Location	Abuse substan-tiated	Exploit. substan-tiated	Neglect substan-tiated	Other issue only	Not substan-tiated	Death Review	Totals
Facilities:							
Choate DC	0	0	0	0	0	1	1
Fox DC	0	0	0	1	0	8	9
Kiley DC	0	0	0	0	1	4	5
Ludeman DC	0	0	0	1	0	3	4
Mabley DC	0	0	0	0	0	4	4
Murray DC	0	0	0	0	0	4	4
Shapiro DC	0	0	0	0	1	6	7
Facility totals	**0**	**0**	**0**	**2**	**2**	**30**	**34**
Community agencies:							
Residential	0	0	14	38	7	118	177
Non-Residential	0	0	0	0	0	2	2
Agency totals	**0**	**0**	**14**	**38**	**7**	**120**	**179**
DD Death Totals	**0**	**0**	**14**	**40**	**9**	**150**	**213**

Trends in Closures

During FY2019, OIG closed a total of 3,965 cases (an increase of 10.5% in relation to FY2018), which includes 3,729 investigative cases of abuse or neglect and 236 death cases. Total allegations and death reports received in FY2019 totaled 3,774, 5.9% fewer than the number of cases closed.

Chart detailing: Trends in Closures



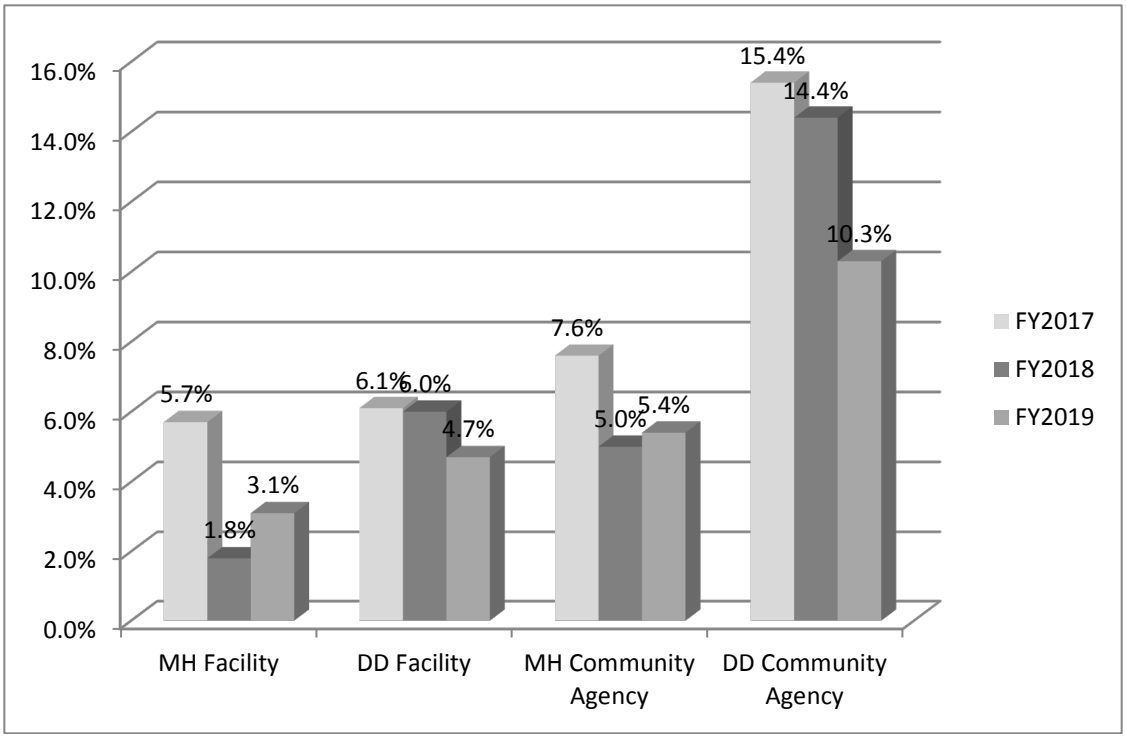
Trends in Investigative Findings

OIG substantiated abuse or neglect in 300 investigations. The substantiation rate or the percentage of allegations that are substantiated is shown in Table 7. The rate of substantiation overall shows a decrease over the past three fiscal years.

Table 7: Substantiation Rates by Location and Fiscal Year, FY2017 through FY2019

Location	FY2017	FY2018	FY2019
MH State Facility	5.7%	1.8%	3.1%
DD State Facility	6.1%	6.0%	4.7%
MH Community Agency	7.6%	5.0%	5.4%
DD Community Agency	15.4%	14.4%	10.3%
Total	**12.7%**	**10.6%**	**7.9%**

Chart of Table 7: Substantiation Rates by Location and Fiscal Year, FY2017 through FY2019



C. Investigative Timeliness

Until May 26, 2017, when Rule 50 was last amended, OIG investigative case reports were mandated to be submitted within sixty working days from assignment, unless there were extenuating circumstances. Although this time requirement has been removed from the administrative rule, it is still included in OIG Directives. Some of the issues that affect timely completion of investigations are the overall number of cases in OIG's caseload, the complexity of the cases within the caseload, and referrals to law enforcement for criminal investigation. 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. If a criminal investigation results in a referral of prosecution, OIG will continue to suspend its investigation until the State's Attorney makes a prosecutorial decision or judicial proceedings have been completed. During this investigative down time, OIG makes monthly contact with the appropriate agency for a status update to track the progress of the investigation. On rare occasions, LLE gives OIG permission to complete the administrative investigation while the criminal investigation is ongoing.

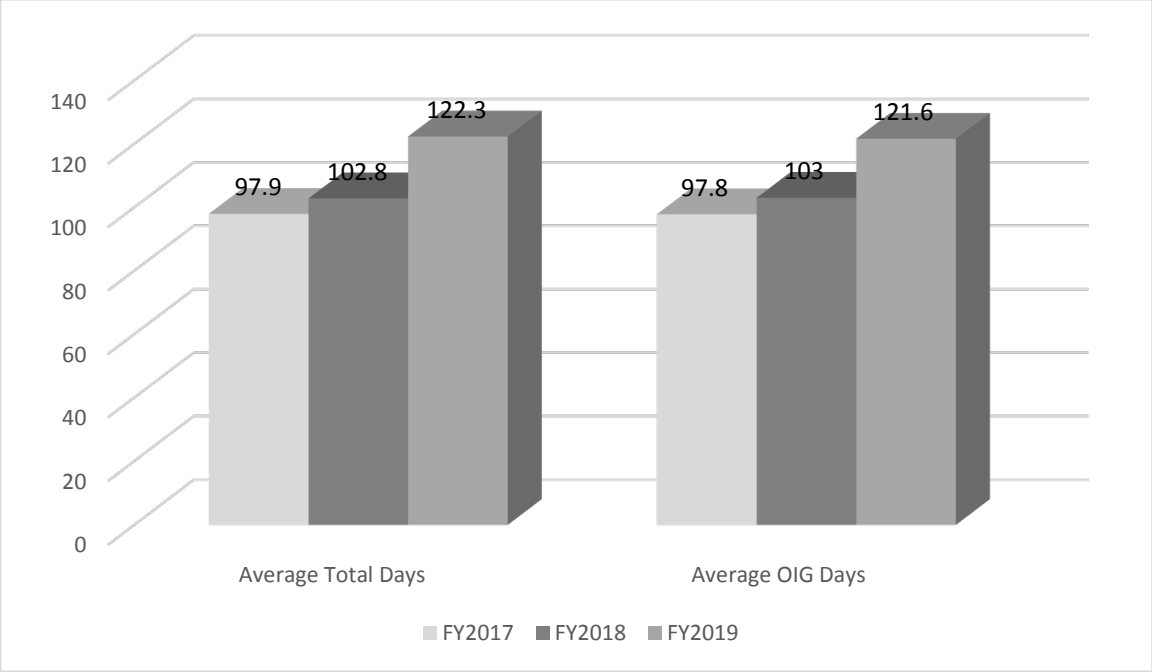
For this reason, OIG counts total time and OIG time separately (see Table 6 below). For the past three years, OIG's average time to completion has remained above the administratively defined investigative limit of sixty days. In FY2019, OIG completed significantly more cases than in FY2018. However, the average time in which OIG completed investigations also increased from FY2018 to FY2019. OIG hired six new investigators during FY2019. Two left during the training period, though, bringing the total number of new investigators to four. One of our most experienced investigators, who had over 25 years of service, also retired during this fiscal year.

Table 8: Average Time to Completion for All OIG Investigations, by Fiscal Year

Investigations	FY2017	FY2018	FY2019
Number completed	3,895	3,543	3,863
Average total days*	97.9	102.8	122.3
Average OIG days*	97.8	103.0	121.6

*Average total days includes all time from initial report until case closure; while average OIG days omits time for delays necessitated by pending Illinois State Police or local law enforcement investigations.

Chart of Table 8: Average Time to Completion for All OIG Investigations, by Fiscal Year



D. Reconsiderations

After an investigation has gone through the review phase and OIG sends the results to the involved facility or community agency, there is a 15-day time frame during which the facility/agency, accused, or victim can request a reconsideration of the findings. During FY2019, OIG received 139 requests to reconsider the findings of 134 investigations (some cases had multiple requests). Of the 139 requests, OIG granted 33 (involving 33 cases) and denied 99 (involving 96 cases), with seven cases pending the decision of the reconsideration process. Of the 33 cases with granted reconsiderations, OIG revised all 33 case reports. OIG also revised two case reports where it denied the reconsideration.

On August 17, 2018, Public Act 100-0943 was signed by Governor Rauner, with an effective date of January 1, 2019. All practices mandated in this act are already in place for the reconsideration request process. OIG makes determinations regarding requests for reconsideration through a multi-level review process. As practiced by OIG and mandated by this Act, one reviewer of the reconsideration request will not have participated in the investigation or approval of the original report. This person historically has been, and will continue to be, the last reviewer to make a recommendation to the Inspector General. Another mandated change is that requestors are no longer required to provide additional information to file a reconsideration request.

Chapter IV: Stopping Abuse and Neglect

OIG's statutory mission reaches beyond investigating. As noted at the outset of this report, OIG has been working to defend against the occurrence of abuse and neglect. This effort is evident in (1) the identification of issues during its site visits each year, (2) the making of recommendations in its investigative reports to identify problems that may lead to recurrent abuse and/or neglect, and (3) the tracking of actions taken in response to those recommendations.

A. Health Care Worker Registry

Once all appeals are exhausted, OIG is required to notify the Illinois Department of Public Health's Health Care Worker Registry of the identity of any person with an OIG substantiated finding of physical abuse, sexual abuse, financial exploitation, or egregious neglect in a Rule 50 setting.

During FY2019:

- OIG referred 48 employees to the Registry;
- OIG referred one employee to the Registry for two separate cases of physical abuse;
- OIG referred one employee to the Registry for six separate cases of financial exploitation from seven victims with amounts totaling more than $15,000.
- Six referrals involved facility employees and 42 involved agency employees;
- 43 of the employees referred to the Registry were direct care staff and five were administrative staff; and
- 46 employees worked for the Division of Developmental Disabilities and two worked for the Division of Mental Health.

Physical Abuse: Physical abuse is defined as staff's non-accidental and inappropriate contact with an individual that causes bodily harm. Directing an individual or person to physically abuse another individual also constitutes physical abuse. Bodily harm is defined as any injury, damage or impairment to an individual's physical condition. Making physical contact of an insulting or provoking nature with an individual also constitutes bodily harm. Substantiated physical abuse accounted for 37 of the 48 referrals to the Registry (77.1%) this fiscal year – six facility staff and 31 DD agency staff.

Sexual Abuse: Sexual abuse is defined as any 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: an 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; or an employee's posting of sexually explicit images of an individual online or elsewhere, whether or not there is contact with the individual. Sexual abuse does not include allowing individuals to, of their volition, view movies or images of a sexual nature or read text containing sexual content unless the individual's guardian prohibits the viewing of those movies or images or reading of that material. In FY2019, there was one referral to the Registry for sexual abuse, a DD agency staff.

Egregious Neglect: Egregious neglect is a finding that an employee grossly failed to adequately provide for or was callously indifferent to, the health, safety, or medical needs of an individual and that that conduct resulted in an individual's death or a serious deterioration in an individual's physical condition or mental condition. In FY2019, OIG made three such referrals, both in agency DD settings.

Financial Exploitation: Financial exploitation is defined as taking unjust advantage of an individual's assets, property or financial resources through deception, intimidation or conversion for the employee's or facility's own advantage or benefit. In FY2019, OIG referred seven agency employees to the Registry for financial exploitation, five of them DD employees and two MH employees.

B. Written Responses

When OIG substantiates abuse or neglect or makes a recommendation regarding other administrative issues during an investigation, the facility or agency must respond in writing. This written response must indicate the action(s) that have been taken or are planned to protect the individual from future occurrences of abuse or neglect and 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 program division of DHS. The program division then reviews and approves the written response, lists the proposed actions, and sends the approved written response to OIG.

FY2019 Issues

In FY2019, OIG sent 200 initial written responses to facilities and 872 to community agencies for a total of 1,072 written responses covering as many cases. OIG received the approved written responses in 942 of those 1,072 cases. OIG also received 112 approved written responses that had been required during a prior fiscal year, totaling 1,054 approved written responses received during FY2019. In the 1,054 written responses received, there were a combined total of 1,550 issues identified.

Table 9: Issues Cited in Approved Written Responses Received, FY2017 through FY2019

Issues	FY2017		FY2018		FY2019	
	Count	Percent	Count	Percent	Count	Percent
Substantiations	407	30.1	478	24.3	304	19.6
Late reporting	204	15.1	257	13.1	200	12.9
Nursing practices	101	7.5	165	8.4	139	9.0
Investigative error	134	9.9	205	10.4	233	15.0
Service plan	105	7.8	392	19.9	306	19.7
Inappr. Interaction	67	4.9	83	4.2	68	4.4
Failure to report	70	5.2	65	3.3	43	2.8
Monitoring/staffing	104	7.7	79	4.0	67	4.3
All other issues	159	11.8	242	12.4	190	12.3
Total issues	**1,351**	**100.0**	**1,966**	**100.0**	**1,550**	**100.00**

This table shows that the total issues OIG cited in FY2019 was 21.2% fewer than in FY2018, following a 45.5% increase in FY2018.

Table 10: Number of Written Responses and Issues Received

Fiscal Year	Number of Written Responses Received from cases during the Year	Number of Written Responses Received from Prior Year(s)	Total Number of Written Responses Received	Total Number of Issues
FY2017	881	97	978	1,351
FY2018	962	407	1,369	1,966
FY2019	948	112	1,050	1,550

FY2019 Actions Taken

OIG may identify multiple issues in a single case, and each issue may require multiple actions. Any single action may involve many people (e.g., a group training of ten employees) or many documents (e.g., a revision of three related forms). For consistency of reporting, OIG counts actions taken. During FY2019, the facilities and agencies performed 1,879 actions (a 21.2% decrease from FY2018) to address the 1,550 issues identified in the 1,054 cases with an approved Written Response. See Table 11.

Table 11 - FY2019 Actions Taken

Type	Number of Actions Taken
Group Training	407
Retraining	356
Discharged	202
Procedural Change	150
Reviewed by Agency/Facility	142
Policy Change	120
Resignation	90
Written Reprimand	74
Habilitation/Treatment Change	68
Counseling	48
Administrative Change	46
Suspension	42
Nothing	35
Fired (Other Cause)	35
Oral Reprimand	26
Transferred	12
Reassignment	8
Supervision	6
Structural Repair	5
Structural Upgrade	4
Performance Evaluation	2
Retirement	1
Total	**1,879**

As noted, OIG investigations continue to identify administrative issues, resulting in responsive actions by the facilities and community agencies. While the DHS program divisions are required to review and approve those actions, the statute gives OIG the responsibility to ensure that those actions are implemented. OIG does this in two ways.

FY2019 Implementation Status Reports

The facility or community agency must list on the written response the date that it implemented all actions. If all actions are not implemented by the time the written response is approved, the facility or community agency must send an implementation status report to OIG every 60 days until every listed action is implemented. On a monthly basis, OIG sends the facility or community agency a reminder letter about any implementation status reports that are overdue. The letter also indicates what is needed to complete the actions on the case.

C. FY2019 Compliance Reviews

OIG also ensures the implementation of responsive actions by obtaining documentation that proves that the implementation occurred. These compliance reviews are outlined in Section 50.80(d) of Rule 50. For example, in cases involving substantiated non-egregious neglect, the agency might require an employee to complete retraining, supervision, discipline or a combination of all three. Once the Division approves the actions, OIG might collect documents reflecting these actions. OIG worked closely with the Divisions to clarify actions on several written responses, resulting in OIG issuing no "Out of Compliance" letters in FY2019.

OIG conducts compliance reviews on two types of written responses. First, each month OIG selects a random sample of all written responses approved by the respective Division during the prior month. Second, each month OIG adds to that sample every approved written response that has been approved for longer than 120 days, but for which the actions listed on it have not yet been implemented.

For FY2019 compliance reviews, OIG randomly selected 191 of the written responses approved, and then added the 6 written responses that were pending over 120 days for a total of 197 compliance reviews. Table 11 below shows the breakdown of all 197 compliance reviews by disability type and location.

Table 11: FY2019 Number of Compliance Reviews on Approved Written Responses

Location	DD Programs	MH Programs	Totals
DHS facilities	24	20	44
Community agencies	143	10	153
Totals	**167**	**30**	**197**

OIG's randomly selected compliance reviews help ensure that the problems and unsafe practices OIG identifies during its investigation are corrected by the facility or agency. Ensuring that corrective action has been taken helps the facilities and agencies effectively address the underlying issues and reduces the likelihood of a recurrence of the abuse or neglect.

Conclusion

OIG takes its responsibility to protect individuals with developmental disabilities and mental illnesses very seriously. OIG continues to mentor new investigators with an eye towards improving the quality and timeliness of investigations. It continues to streamline the Intake process as well as the testing procedures used for its outside investigative training of facility and community agency staff. OIG will continue to work to find ways to improve both the quality and timeliness of its investigations as well as its ability to foster safe, therapeutic care for individuals receiving developmental disabilities and/or mental health services from a facility or community agency operated, licensed, funded or certified by DHS.

401 South Clinton Street Chicago, IL 60607
100 South Grand Avenue East Springfield, IL 62762
www.dhs.state.il.us

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