



JB Pritzker, Governor

Dulce M. Quintero, Secretary Designate

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DATE: December 30, 2024

MEMORANDUM

TO: The Honorable John F. Curran, Senate Minority Leader
The Honorable Don Harmon, Senate President
The Honorable Tony McCombie, House Minority Leader
The Honorable Emanuel "Chris" Welch, Speaker of the House

FROM: Dulce Quintero *Dulce Quintero*
Secretary Designate *by Michael*
Illinois Department of Human Services

SUBJECT: IDHS OIG FY24 Annual Report

The Illinois Department of Human Services respectfully submits the IDHS OIG FY24 Annual Report on behalf of the Office of the Inspector General in order to fulfill the requirements set forth in Department of Human Services Act, 20 ILCS 1305/1-17(v).

If you have any questions or comments, please contact Amy Tarr, OIG Policy Manager, at amy.tarr@illinois.gov or 217-891-4002.

cc: The Honorable JB Pritzker, Governor
John W. Hollman, Clerk of the House
Tim Anderson, Secretary of the Illinois Senate
Legislative Research Unit
State Government Report Center



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



IDHS Office of the Inspector General

FY24 Annual Report



December 17, 2024

To Governor Pritzker and Members of the Illinois General Assembly:

In FY24, OIG took significant steps toward becoming a sufficiently staffed and resourced organization. While OIG had 73 staff members at the end of FY23, as of the end of FY24, OIG had 91 employees. This represents a 25% increase in staff in only one fiscal year. While the increase in staff is welcome, OIG still lacks sufficient staff to conduct its investigations in a timely manner. Based on caseload numbers, OIG estimates that a filled headcount of at least 120 would be necessary to address rising workloads.

In a trend that has remained consistent since FY22, the number of complaints that OIG receives annually continues to increase. In FY24, OIG's complaints rose, from 12,386 to 15,366. This reflects a 24% increase from FY23, and an 80% increase since FY20. During FY24, OIG completed 2089 cases, 246 of which were substantiated. OIG's cases resulted in 267 findings against accused employees (95 findings of abuse and 165 findings of neglect, 3 findings of egregious neglect, 3 findings of financial exploitation, and 1 finding of material obstruction of an investigation) and 16 findings of neglect against facilities and community agencies.

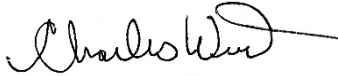
OIG continues to push toward a more systems-focused approach with the goal of reducing instances of abuse and neglect across the agencies and facilities within its jurisdiction. To that end, in FY24, OIG proposed new legislation that would give OIG additional authority to conduct discretionary, in-depth reviews targeted at addressing the root causes of abuse and neglect at agencies and facilities across the State. On August 2, 2024, Governor J.B. Pritzker signed SB 857 into law (Public Act 103-0752), and OIG is in the process of hiring a staff member who will lead this new initiative. I am excited to see the impact that OIG will have given this new authority.

OIG also looks forward to the potential impact of installing cameras at the SODCs. The process of installing cameras at the SODCs was initiated after a series of high-profile investigations at Choate Developmental Center (DC) and several cases wherein OIG recommended that cameras be installed at SODCs in order to deter abuse and, in some cases, exonerate falsely accused staff. OIG is encouraged that the barriers to IDHS beginning to install cameras have been overcome. According to the Division of Developmental Disabilities (DD), as of October 15, 2024, 335 cameras are wired and installed at Choate and 79 cameras are wired and installed at Fox Developmental Center (DC). Wiring for cameras has been completed at Kiley and Mabley DC and wiring is in progress at Ludeman, Murray, and Shapiro DCs. OIG is hopeful that progress will continue in FY25 and that

cameras will, in time, both reduce instances of abuse and neglect at SODCs and assist and accelerate the completion of the OIG's investigations and employee administrative leaves.

I am thankful to the hard-working and dedicated staff at OIG, without whom none of the work our office does would be possible. As OIG expands, there will be growing pains. However, I am confident that OIG will be better equipped to meet its demands in the coming years.

Sincerely,

A handwritten signature in cursive script, appearing to read "Charles Wright".

Charles Wright
Acting Inspector General

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Chapter 1: Summary of OIG’s FY24 Data

A. Notable FY24 Data

The FY24 data demonstrates that OIG continues to experience a significant increase in Intake calls and opened investigations. Most notably:

- OIG’s Intake Bureau processed 15,366 calls, which is a 24% increase over FY23, and an 80% from FY20.
- OIG opened 4,059 investigations of abuse or neglect (including death reports), which is a 16% increase over FY23, and a 45% increase from FY20.
- OIG’s cases resulted in 267 findings against accused employees (95 findings of abuse and 165 findings of neglect, 3 findings of egregious neglect, 3 findings of financial exploitation, and 1 finding of material obstruction of an investigation) and 16 findings of neglect against facilities and community agencies.
- OIG made final reports to the HCWR for 68 employees’ names and 70 findings, meaning either the employee did not appeal the finding, or it was determined that the conduct warranted the reporting after a hearing.

For a more complete detailing of OIG’s FY24 metrics, *see infra* Chapters 2 & 3.

B. Hiring Accomplishments and Challenges

During FY24, OIG remained steadfast in posting positions with the goal of reaching sustainable staffing levels. As a result, even with retirements and attrition, OIG’s filled headcount went from 73 full-time employees (FTE) as of June 30, 2023 to 91 FTE as of June 30, 2024, a 25% increase.

During FY24, OIG hired 34 staff, the positions listed below:

Position	# of Hires
Deputy Inspector General	1
Bureau Chief	2
Investigative Team Leader	1
ISI II	21
Administrative Assistant II	2
Office Administrator (III and IV)	6
MPAIII-1	1
Total	34

During FY24, OIG had the following attrition:

Reason for Leaving	# of Staff
Transfer	3
Retirement	8
Resigned	4
Returned to Prior State Position	1
Total	16

Additionally, as of June 30, 2024, OIG had the following 40 positions at various stages of the hiring process.

Position	# Pending
Bureau Chief	1
Medical Analyst	1
Data Manager	1
Compliance Analyst	1
Trainer	2
ISI II	30
Executive 1	1
OA IV	1
OA	2
Total	40

Although a number of positions have been filled, which is good news, unfortunately, the delays in State hiring that affected OIG in FY22 and FY23 continued to impact OIG operations in FY24. Over half of the positions that were filled in FY24 (53%) took 7 months or longer to fill, as illustrated below, and two positions took 15 months to fill.

# of Months	# of Hires
15 months	2
13 months	1
12 months	3
11 months	2
10 months	4
9 months	3
8 months	1
7 months	2

In OIG's FY23 Annual Report, OIG reported that the North Bureau was the starkest example of staffing shortages at OIG. While North Bureau would normally have seven investigators, one Bureau

Chief, and two Investigative Team Leaders when fully staffed, North Bureau had only two full-time investigators during the majority of FY23. During FY24, OIG hired a North Bureau Chief and 7 staff (2 of which have transferred to other sections of OIG). The majority of the North Bureau hires occurred in December 2023 and January 2024.

The significant staff shortages during FY22 and FY23, together with the substantial efforts required to train newly hired staff resulted in a significant decrease in productivity for the Northern Bureau during FY24. That said, since the end of FY24, North Bureau’s productivity has been steadily increasing as the bureau becomes better staffed and more experienced. Accordingly, OIG is hopeful that case completions will rise in FY25.

Chapter 2: OIG’s FY24 in Numbers

A. OIG Hotline Calls and Referrals

During FY24, the OIG’s Intake Bureau processed 15,366 calls, as reflected in the below chart, a 24% increase over FY23, and an 80% since FY20.¹²

OIG Intake Bureau Processed Calls FY20-FY24		
Year	# of Calls	Annual % Change
FY20	8,558	NA
FY21	8,852	3% Increase
FY22	9,944	12% Increase
FY23	12,386	25% Increase
FY24	15,366	24% Increase

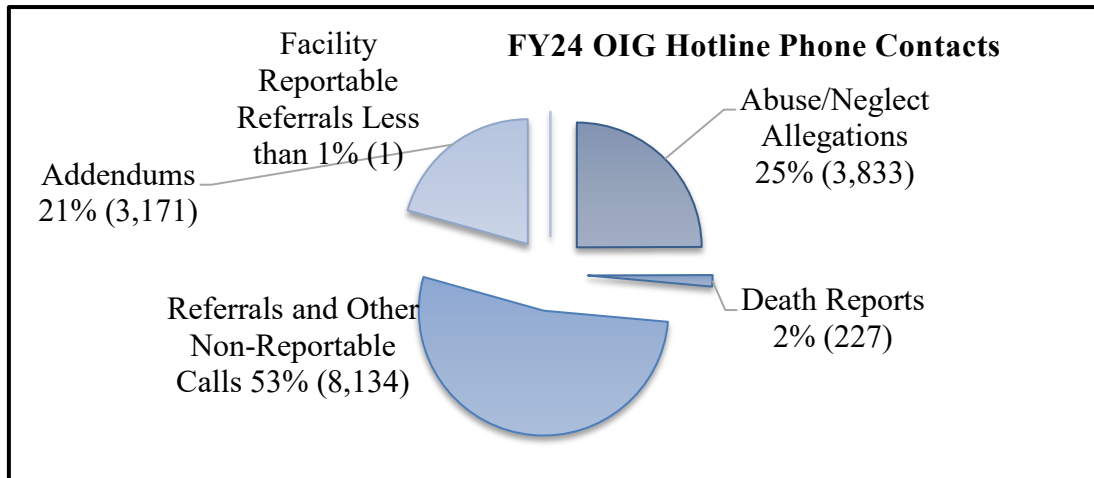
As background, OIG’s Intake Bureau is staffed by a Bureau Chief, an Investigative Team Leader, and seven Intake Investigators who answer calls during business hours, and a contracted answering service that answers calls during the evening and overnight hours. OIG management is available for after-hour calls regarding reports of deaths or serious incidents and calls coming from anonymous sources.

OIG receives and processes complaints alleging abuse (physical abuse, sexual abuse, and mental abuse), neglect, financial exploitation, and material obstruction of an investigation, as well as death reports (reports of death where abuse or neglect is not suspected) by employees of facilities and community agencies that provide mental health and/or developmental disabilities services and that

¹ During FY23, OIG referred 8 Facility Reportable Referrals for internal investigations. Rule 50 (59 Ill. Adm. Code 50.30) provides that a reportable allegation can be referred to a facility or agency when the primary facts relevant to the allegation have already been identified and additional investigative work by OIG would be of minimal value; the facility or agency is better positioned to immediately address the allegation; the allegation, if true, would be unlikely to result in a report to the Health Care Worker Registry; or the allegation does not indicate an emergency situation or that an individual is in imminent danger. While OIG only made 1 Reportable Referred Intake during FY24, OIG anticipates this number will increase significantly during FY25.

² For purposes of Chapter 2, unless specifically stated otherwise, Financial Exploitation allegations are included within the category of Abuse.

are operated, licensed, funded, or certified by IDHS. 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 referrals and other 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 FY24, OIG had 6,711 referrals and other non-reportable calls. The following table reflects the recipients of these calls:

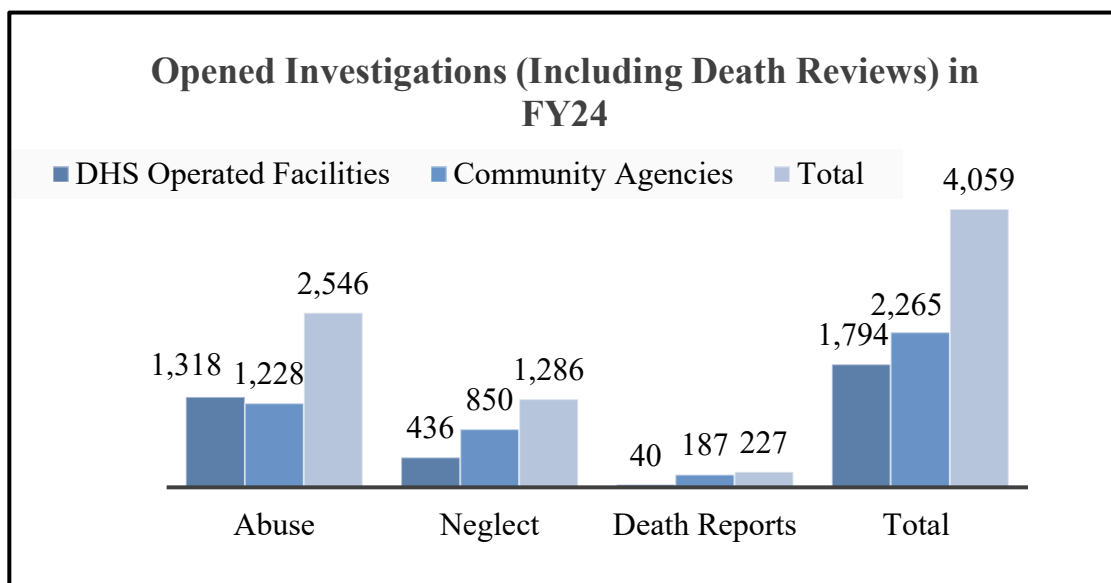
Referral Location	Total Referred	%
Local Community Agency or Facility	3,842	57.2%
Illinois Department of Public Health	306	4.6%
DHS Division of Developmental Disabilities	189	2.8%
Illinois Department on Aging	103	1.5%
DHS Bureau of Accreditation, Licensure & Certification /Bureau of Pharmacy and Clinical Support Services	48	0.7%
Law Enforcement	36	0.5%
DHS Division of Mental Health	33	0.5%
Illinois Department of Healthcare and Family Services	82	1.2%
Illinois Department of Children and Family Services	52	0.8%
DHS Division of Rehabilitation Services	47	0.7%
DHS Substance Use Prevention & Recovery	12	0.2%
Illinois Department of Financial and	14	0.2%

Professional Regulation		
Office of Executive Inspector General	29	0.4%
Other	1,918	28.6%
Total Referred	6,711	

B. Opened Investigations (Including Death Reviews)

During FY24, OIG opened a total of 4,059 abuse or neglect investigations (including death reviews), 565 more than in FY23, or 16%, and a 45% increase from FY2020.

Opened Investigations (Including Death Reviews) FY20-FY24		
Year	# of Opened Investigations (Including Death Reviews)	Annual % Change
FY20	2,800	N/A
FY21	2,333	16% Decrease
FY22	2,991	28% Increase
FY23	3,494	16% Increase
FY24	4,059	16% Increase



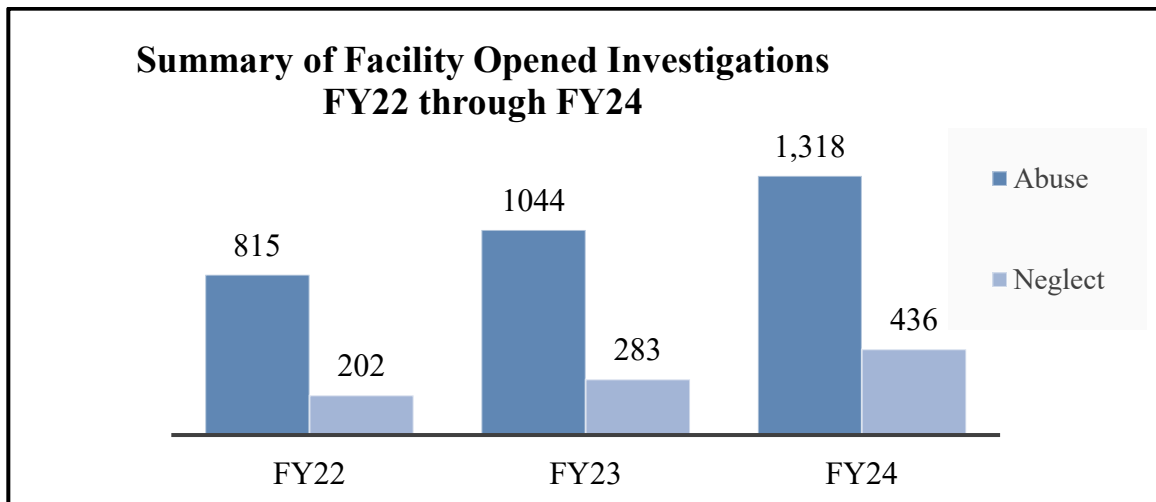
- Opened abuse investigations pertaining to IDHS-operated facilities and community agencies increased from 2,208 in FY23 to 2,546 in FY24, or 15%.
- Opened financial exploitation investigations decreased by 12% from FY23 to FY24.
- Opened neglect investigations pertaining to IDHS-operated facilities and community agencies increased by 221 from FY23 to FY24, or 21%.

The following tables provide a detailed breakdown of the opened investigations in FY24 by type and location.

Facilities

During FY24, OIG opened 1,754 abuse or neglect investigations pertaining to the IDHS-operated facilities, an increase of 32% from FY23.

- 1,318 of the 1,754 opened facility investigations were for abuse (which included 54 opened investigations of financial exploitation).
- Abuse opened investigations accounted for 74% of the total opened investigations at facilities, which is 3% less than FY23 (previously 77%).
- 436 of the 1,794 facility opened investigations in FY24 were for neglect.
- The number of FY24 neglect opened investigations increased by approximately 54% from FY23.



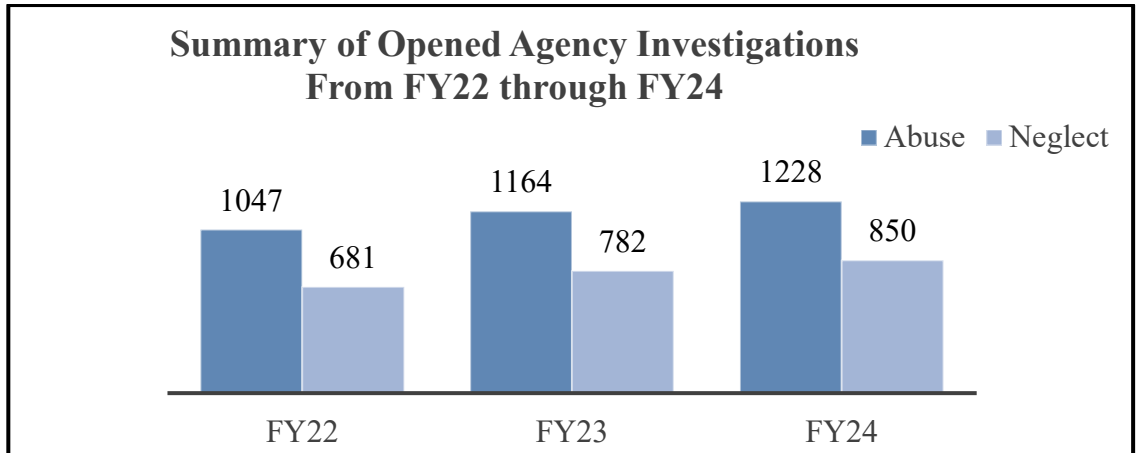
Community Agencies

During FY24, OIG opened 2,078 abuse or neglect investigations pertaining to community agencies, a 6.8% increase from FY23.

- Of the 2,078 community agency investigations, there were 1,228 opened investigations for abuse, including 84 financial exploitation opened investigations.
- From FY23 to FY24, the total abuse investigations pertaining to community agencies increased 5.5%.
- Abuse investigations as a percent of community agency investigations received decreased 1%, from 60% (FY23) to 59% (FY24).
- OIG opened 850 investigations for neglect pertaining to community agencies in FY24, an 8.7% increase from the 782 neglect investigations OIG received in FY23.

In FY24, opened investigations pertaining to community agencies accounted for 54% of the total abuse and neglect opened investigations. This number is generally reflective of the fact that

significantly more individuals receive MH/DD services at community agencies than at State-operated Facilities.



Opened Investigation Type and Death Reviews

The following tables show the opened investigations of abuse and neglect and death reviews during FY24, categorized by the type of investigation and program location. In addition to the above-described abuse or neglect investigations that OIG opened during FY24, OIG opened death reviews regarding 227 individuals who were or had been receiving MH/DD services in facility or community agency programs, as compared 221 death reviews during FY23.

FY24 Opened Investigations (Including Death Reviews) by Mental Health Location							
Location	Allegations Received						Death Reports
	Physical Abuse	Sexual Abuse	Mental Abuse	Financial Exploitation	Neglect	Total	
Mental Health Centers:							
Alton	44	6	60	5	27	142	0
Chester	93	23	41	2	34	193	0
Chicago-Read	33	4	50	20	67	174	0
Choate	11	1	10	0	3	25	0
Elgin	55	27	58	14	59	213	4
Madden	14	8	18	1	11	52	0
Packard	18	10	31	1	4	64	1
Facility Totals	268	79	268	43	205	863	5

Community Agencies:							
Residential	12	6	39	6	28	91	19
Non-Residential	12	9	18	12	18	69	7
Agency Totals	24	15	57	18	46	160	26
Total Opened Investigations and Death Reviews	292	94	325	61	251	1023	31

FY24 Opened Investigations (and Death Reviews) by Developmental Center Location							
Location	Allegations Received						Death Reports
	Physical Abuse	Sexual Abuse	Mental Abuse	Financial Exploitation	Neglect	Total	
Developmental Centers:							
Choate	153	8	91	5	57	314	3
Fox	2	0	0	0	6	8	5
Kiley	64	2	24	2	62	154	1
Ludeman	55	0	13	2	29	99	7
Mabley	24	0	4	1	14	43	2
Murray	69	0	12	0	29	110	9
Shapiro	110	4	14	1	34	163	8
Center Totals	477	14	158	11	231	891	35
Community Agencies:							
Residential	525	41	340	62	742	1710	155
Non-Residential	78	15	49	4	62	208	6
Agency Totals	603	56	389	66	804	1,918	161
Total Opened Investigations and Death Reviews	1080	70	547	77	1035	2,809	196

Opened Investigations (and Death Reviews) by Bureau

Bureau	Deaths	Financial Exploitation	Mental Abuse	Neglect	Physical Abuse	Sexual Abuse	Grand Total
Central	63	29	200	251	187	39	769
Cook	27	37	168	251	213	32	728
Metro	34	15	114	204	296	15	678
North	48	40	174	329	266	37	894
South	55	17	216	250	411	41	990
Total	227	138	872	1,285	1,373	164	4,059

Percent Increase in Opened Investigations (and Death Reviews) from FY23 to FY24, by Bureau

Bureau	% Increase in Opened Investigations (and Death Reviews)
Central	14.1%
Cook	30.5%
Metro	20.0%
North	0.9%
South	22.1%

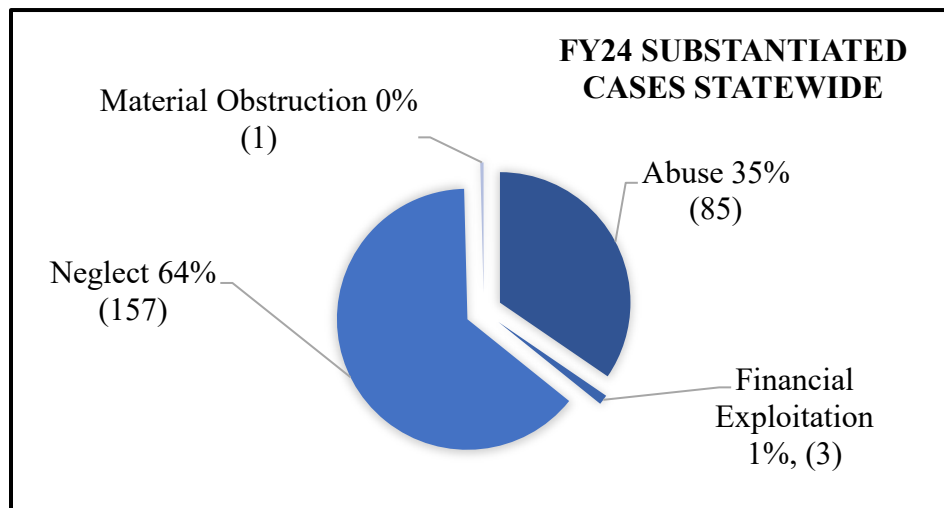
C. Findings

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 246 of the 2,089 investigations it completed in FY24, including 157 substantiated neglect cases, 85 substantiated abuse cases, 3 substantiated financial exploitation cases, as well as 1 substantiated material obstruction of an investigation case. Of the 246 cases where OIG substantiated abuse or neglect, OIG made a total of 283 findings (in some cases OIG will substantiate abuse or neglect against multiple employees or entities), which includes 267 total findings against accused employees and 16 findings against agencies or facilities.

The below tables reflect: (1) FY24 Substantiated Cases Statewide by Category; (2) FY24 Substantiated Finding Types by Accused Employee; (3) FY24 Substantiated Findings Against Agencies and Facilities; (4) Substantiation Rates for FY22 through FY24; (5) Substantiated Abuse and Neglect Cases by MH Location; and (6) Substantiated Abuse and Neglect Cases by Developmental Location.



FY24 Substantiated Finding Types Against Accused Employees							
	Physical Abuse	Sexual Abuse	Mental Abuse	Financial Exploitation	Neglect	Egregious Neglect	Material Obstruction
Agency Employees							
DD	29	4	30	2	143	3	1
MH	3	2	4	1	3	0	0
Total	32	6	34	3	146	3	1
Facility Employees							
DD	8	0	6	0	13	0	0
MH	7	0	2	0	6	0	0
Total	15	0	8	0	19	0	0
Grand Total	47	6	42	3	165	3	1

FY24 Substantiated Findings Against Agencies and Facilities	
Agency Substantiated Findings⁴	
DD – Neglect	12
MH - Neglect	1
Facility Substantiated Findings	
DD - Neglect	2
MH - Neglect	1
Total Agency and Facility Substantiated Findings	16

FY22 through FY24 Substantiated Case Trends

OIG’s overall substantiation rate remained almost the same - in FY24 the substantiation rate was 11.8% and in FY23 it was 12.1%.

Substantiation Rate – FY22 through FY24			
Location	FY22	FY23	FY24
MH State Facility	3.4%	3.3%	3.7%
DD State Facility	7.0%	7.9%	5.4%
MH Community Agency	4.8%	12.0%	11.3%
DD Community Agency	15.8%	16.7%	18.2%
Total	11.5%	12.1%	11.8%

FY24 Findings by Mental Health Location						
Location	Abuse Substantiated	Financial Exploitation Substantiated	Neglect Substantiated	Material Obstruction	Not Substantiated³	Findings Total
Mental Health Centers						
Alton MHC	2	0	1	0	80	83
Chester MHC	3	0	5	0	95	103
Chicago-Read MHC	0	0	0	0	87	87
Choate MHC	1	0	0	0	24	25
Elgin MH	0	0	0	0	27	27
Madden MHC	2	0	0	0	37	39
Packard MHC	1	0	1	0	60	62
Center Totals	9	0	7	0	410	426
Community Agencies						
Residential	6	1	2	0	48	57
Non-Residential	2	0	1	0	38	41
Agency Totals	8	1	3	0	86	98
Finding Totals	17	1	10	0	496	524

³ Of those Not Substantiated, OIG made recommendations on 27 MH Facility or Community agency cases.

FY24 Findings by Developmental Location						
Location	Abuse Substantiated	Financial Exploitation Substantiated	Neglect Substantiated	Material Obstruction	Not Substantiated⁴	Findings Total
Developmental Centers						
Choate DC	4	0	5	0	207	216
Fox DC	0	0	2	0	5	7
Kiley DC	1	0	1	0	22	24
Ludeman DC	1	0	2	0	46	49
Mabley DC	0	0	0	0	4	4
Murray DC	4	0	3	0	58	65
Shapiro DC	0	0	0	0	49	49
Center Totals	10	0	13	0	391	414
Community Agencies						
Residential	48	1	124	1	738	912
Non-Residential	10	1	10	0	90	111
Agency Totals	58	2	134	1	828	1,023
Finding Totals	68	2	147	1	1,219	1,437

FY24 Substantiated Death Cases

OIG closed 132 death cases (this includes 125 death reviews and 7 full death investigations) during FY24, a decrease from the 170 death cases OIG closed during FY23. Of the 132 closed death cases, OIG determined that there was no suspicion of abuse or neglect in 125 of the cases. With respect to the 7 death cases where OIG subsequently opened an abuse or neglect investigation, OIG substantiated 4 cases for neglect. As to the other 3 cases that OIG did not substantiate, OIG identified issues that required a written response from the agency or facility in 1 of those cases.

D. OIG’s Efforts to Reduce the Number of Division of Developmental Disabilities Employees on Paid Administrative Leave

Over the last several fiscal years, one of OIG's priorities has been to reduce the number of facility employees that are on paid administrative leave because of OIG investigations. As background, a

⁴ Of those Not Substantiated, OIG made recommendations on 166 DDD Facility or Community Agency cases.

2001 memorandum of understanding between IDHS and AFSCME provides that employees who are the subject of a complaint alleging abuse or neglect, absent agreeing to serve in a non-resident facing position, 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 subject of criminal law enforcement investigations that extend beyond 60 days. As investigatory best practices dictate that OIG suspend its administrative investigation until the criminal investigation and any ensuing proceedings are completed, OIG has limited ability to reduce the number of facility employees who are on paid administrative leave due to ongoing criminal investigations, which can often 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 because of an OIG administrative investigation.

The below table reflects the number of employees on paid administrative leave due to ongoing OIG investigations from July 2020 through August 2024 (as explained above, that number does not include employees on paid administrative leave who are the subjects of ongoing criminal investigation or prosecution).

Facility Employees on Paid Administrative Leave Due to OIG Investigations⁵	
July 2020	55
June 2021	39
August 2022	46
June 2023	53
August 2024	175

As shown above, there was a significant increase in employees on paid administrative leave as of August 2024 when compared to employees on administrative leave as of June 2023. Contributing factors to this increase include rising OIG staff caseloads, the increase in facility cases, and significant OIG staff shortages, which OIG highlighted in its FY22 and FY23 annual reports. The shortages were particularly acute in OIG's North and Metro bureaus, which account for a significant portion of the DD staff members on administrative leave.

OIG has a multifaceted approach to reducing the number of facility employees who are placed on administrative leave. First, OIG continues to use its authority under 405 ILCS 5/3-210 of the Mental Health and Developmental Disabilities Code, which allows employees to return to work once OIG has determined that the allegation or allegations against the employee will be unsubstantiated or unfounded in OIG's final investigative report. As a result of this process, OIG has been able return employees to work more quickly, which helps with staffing levels at the

⁵ These numbers reflect the number of IDHS Division of Developmental Disabilities employees on paid administrative leave due to OIG Investigations.

facilities. More specifically, during FY24, OIG authorized the return to work of at least 75 facility employees using this legislative amendment, an increase from the 45 facility employees returned to work in FY23.

Second, OIG is working with DD to ensure that facilities are compliant with 405 ILCS 5/3-210, which requires that staff members be placed on administrative leave when there is credible evidence that a facility employee is the perpetrator of physical abuse, sexual abuse, financial exploitation, egregious neglect, or material obstruction of investigation. While some SODCs make a credible evidence assessment prior to putting accused staff members on administrative leave, there are inconsistencies in process between SODCs, which can result in elevated numbers of staff on administrative leave at certain facilities. In FY25, OIG will continue to collaborate with DD to ensure that SODC staff put on administrative leave are placed appropriately and consistently across the SODCs, with the goal of maintaining the safety of individuals.

Last, in October 2024, OIG began utilizing its reportable referred process, which, pursuant to Rule 50 (59 Ill. Adm. Code 50.30), allows reportable allegations to be referred to a facility or agency when certain criteria are met. Specifically, OIG may refer cases when the primary facts relevant to the allegation have already been identified and additional investigative work by OIG would be of minimal value; the facility or agency is better positioned to immediately address the allegation; the allegation, if true, would be unlikely to result in a report to the Health Care Worker Registry; or the allegation does not indicate an emergency situation or that an individual is in imminent danger.

E. Reconsiderations of OIG Findings

In FY24, OIG received and reviewed 61 requests for reconsideration of OIG's investigative findings or recommendations, in connection with 60 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-layered review of the request, which review includes at least one OIG employee who did not participate in the investigation or approval of the investigative report at issue. OIG reviews the information provided in the reconsideration request and all evidence gathered during the original investigation. The Inspector General ultimately makes the final determination as to whether the request should be:

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

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

In FY24, OIG received and processed 14 fewer reconsiderations than in FY23. Of the 61 reconsiderations OIG received in FY24, OIG denied 81% and granted 19%, as reflected in the below

table. In comparison, of the 75 reconsiderations⁶ OIG received in FY23, OIG denied 76% and granted 24%.

FY24 Reconsideration Outcomes	Number of Cases	Outcomes in %
Denied	48	79%
Denied, with the Issuance of an Amended Report	1	2%
Granted, with the Issuance of an Amended Report	2	3%
Granted, and Reopened Investigation	10	16%
Total Reconsiderations	61	

FY23 Reconsideration Outcomes	Number of Cases	Outcomes in %
Denied	52	69%
Denied, with the Issuance of an Amended Report	5	7%
Granted, with the Issuance of an Amended Report	9	12%
Granted, and Reopened Investigation	9	12%
Total Reconsiderations	75	

F. Written Responses

When OIG substantiates an allegation, or if a recommendation is made in an investigative report, the facility or agency must respond to the substantiated finding and/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, neglect or financial exploitation; (2) prevent reoccurrences of the substantiated allegation(s) generally; and (3) eliminate any other problem(s) identified during the investigation.

The facility or agency has 30 calendar days from the date OIG sends the investigative report to submit a written response to the appropriate IDHS program division (DDD or DMH). *See* Department of Human Services Act, 20 ILCS 1305/1-17(n). The program division then reviews and approves the written responses and sends the written response to OIG.

In FY24, OIG received 120 approved written responses from State-operated facilities and 417 from community agencies for a total of 537 written responses, regarding OIG’s findings and recommendations.⁷ With respect to the above-described written responses, facilities and agencies detailed the following actions related to OIG’s findings and recommendations:

⁶ The FY23 Annual Report showed 75 reconsiderations, which was a data error. The correct number of reconsiderations in FY23 was 71. The numbers in the FY23 Reconsideration Outcomes table contains the corrected FY23 Reconsideration Outcomes.

FY24 Actions Taken			
Personnel Action		Administrative Actions	
Discharged	303	Individual Retraining	287
Written Reprimand	66	Group Training	319
Resignation	83	Policy/Procedural Change	178
Suspension	31	Reviewed	138
Reassigned	6	Treatment Plan Change	59
Counseling	42	Administrative Change	36
Retirement	4	Structural Repair/Upgrade	28
Oral Reprimand	5	No Action	25
Discharged (Other Cause)	27	Supervision	7
		Individual Transferred	6

G. Compliance Reviews

Once IDHS' DD and MH Divisions approve the facilities' and agencies' written responses to OIG's findings and recommendations, OIG conducts compliance reviews to ensure that the facilities and agencies acted 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. If necessary, OIG can request additional 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 FY24 by location and program division.⁷

⁷ These numbers include approved written responses OIG received in FY24 regarding cases it completed in FY23.

FY24 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	84	24	29%	36	7	19%
Community Agencies	405	64	16%	12	0	0%
Totals	489	88	18%	70	7	10%

With respect to these compliance reviews, OIG issued 3 “Out of Compliance” letters in FY24 to the same agency for 3 separate cases. The agency subsequently submitted documents, and OIG found all three cases in compliance.

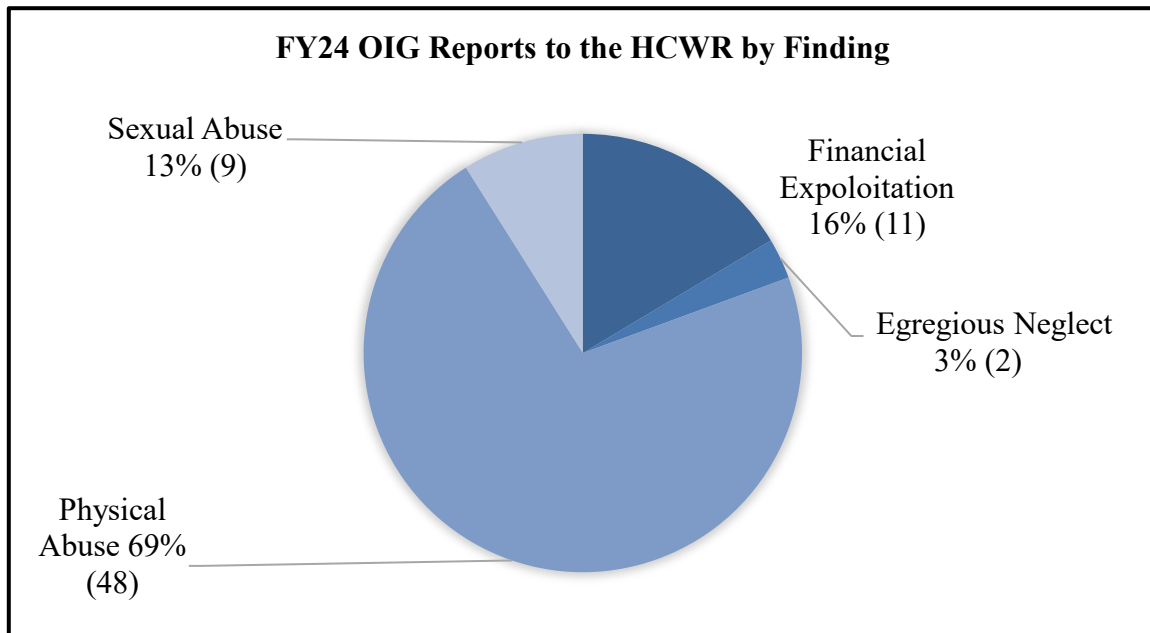
H. Health Care Worker Registry

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 FY24, OIG completed 59 substantiated cases which required initial reports to the HCWR of the employee’s name and the nature of OIG’s finding. During FY24, OIG also made final reports to the HCWR for 68 employees’ names and 70 findings, meaning either the employee did not appeal the report, or, after a hearing, it was determined that the conduct warranted the reporting.⁸⁹ Of the 68 employees, 53 of the reported employees were from DDD and 15 reported employees were from DMH. For FY24, OIG’s reports to the HCWR placements by finding are reflected in the below chart:

⁸ The 68 final reports OIG made to the HCWR encompassed cases that it substantiated during FY19 through FY24.

⁹ Two employee’s names were reported for two separate cases.



HCWR Administrative Appeal Hearings

If an employee requests an administrative appeal of OIG’s HCWR referral, IDHS has to prove by a preponderance of the evidence that OIG’s finding of abuse or neglect warrants the reporting of the employee to the HCWR. During FY24, twelve employees filed appeals challenging their names and findings being reported to the HCWR. Four of those appeals were resolved by the end of FY24. One of the employee’s name and finding was placed on the HCWR, one of the employees withdrew their HCWR petition, and two petitions were dismissed for failure to appear. Eight of those appeals remain pending at the end of FY24.

The IDHS Bureau of Hearings decided 19 appeals that were filed prior to FY24. The outcomes were as follows.

- Nine employees’ appeals were denied, and their names were reported to the HCWR;
- Four employees’ appeals were granted at hearing, and they were not placed on the HCWR;
- Three appeals were dismissed (two due to failure to appear for the hearing and one due to lack of jurisdiction);
- Two petitioners withdrew their appeal and were placed on the HCWR; and
- One appeal was stipulated (that the employee was not reported to the HCWR because the facility employee was successful during a union arbitration; therefore, could not be reported to the HCWR.
- Four appeals filed prior to FY24 remained pending at the end of FY24.

HCWR Removal Hearings

An employee may petition IDHS to remove their name and OIG’s substantiated finding from the HCWR. In that case, the burden is on the petitioner to prove by a preponderance of the evidence that removal of the petitioner’s name and OIG 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 substantiated 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 FY24, eight employees requested hearings to have their names and findings removed from the HCWR. The following is the status of those eight requests:

- Two petitions were dismissed because the employee failed to appear for a status hearing, so the two employees’ names are on the HCWR;
- Three employees withdrew their petitions prior to the hearing so their names are on the HCWR;
- OIG agreed one employee met the criteria to be removed from the HCWR so that employee’s name was removed from the HCWR.
- Two petitions remain pending at the end of FY24.

Arbitrations

Following the completion and issuance of a substantiated OIG investigative report, AFSCME employees working at IDHS facilities can request labor arbitrations, in which the employees may challenge adverse employment actions based on OIG’s cases and findings. During FY24, OIG there were no arbitrations that went to full hearing. The following four were resolved prior to arbitration by agreement between CMS and AFSCME.

OIG Finding	Resolution Agreement
OIG substantiated physical abuse against a facility employee who slammed an individual’s feet into their wheelchair’s footrests, picked the individual up and forcefully shoved them into their wheelchair, and forcefully grabbed the individual’s arm out of their pants, while yelling at them.	The employee returned to employment in a non-direct care position, received a 30- day suspension, received partial back pay/partial LOA without pay. The employee did not lose seniority, and their pay was not reduced.

<p>OIG substantiated sexual abuse against a facility employee who showed an individual sexually explicit photos of the employee, the employee talked with the individual for an extended period on the phone; allowed the individual to braid the employee's hair; and the employee pinched the individual's buttocks.</p>	<p>The employee had an unpaid LOA, then resigned their position. This employee's name and finding has been placed on the Health Care Worker Registry.</p>
<p>OIG substantiated physical abuse against the facility employee when he used excessive force in the restraint of the individual when he placed the individual down, face first on the restraint bed, forcibly drove his right knee into the back of the individual's head and held the individual in place with his knee for one minute. Upon removing his knee, he grabbed the individual by the back of the head/neck and wrenched it to the side.</p>	<p>The employee resigned their position (disciplinary action overturned upon resignation) with no reinstatement rights and received partial back pay/ partial unpaid leave of absence. The employee filed a 50.90, which they withdrew. The employee's name and finding has been placed on the HCWR.</p>
<p>OIG substantiated physical abuse against a facility employee who lunged toward an individual with his hands and grabbed the individual's arms and upper shoulder which knocked the individual over, out of his chair. The employee then initiated an unaccompanied physical hold. These actions provoked the individual to become combative, resulting in the individual being placed in 5-point physical restraints.</p>	<p>The employee resigned their position (disciplinary action overturned upon resignation) with no reinstatement rights and received an unpaid leave of absence. The employee filed a 50.90, which they withdrew. The employee's name and finding has been placed on the HCWR.</p>

Civil Service Hearings

Following the completion and issuance of a substantiated OIG investigative report, merit compensation employees working at IDHS facilities can request a Civil Service Hearing, in which the employees may challenge adverse employment actions based on OIG's cases and findings. During FY24, OIG received the results of one Civil Service Hearing. In that decision, the employee prevailed.

Stipulations

OIG instituted a process in FY22 whereby a stipulated disposition can be approved without requiring the accused employee to file an appeal. In 6 cases, OIG determined that the circumstances surrounding the finding did not warrant reporting to the HCWR and that a stipulated decision not to report the employees' names was appropriate.

I. 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.

FY24 Scope

In addition to addressing recommendations from previous fiscal years, the scope of the FY24 site visits was to evaluate whether each facility's Human Rights Committee was performing its intended duties and responsibilities. The site visit dates were as follows:

Alton Mental Health Center	August 30, 2023-December 6, 2023
Chester Mental Health Center	September 6, 2023 – January 10, 2024
Chicago Read Mental Health Center	September 25, 2023 – January 24, 2024
Choate Developmental Center	January 30, 2024 – April 10, 2024
Choate Mental Health Center	January 30, 2024 – March 12, 2024
Elgin Mental Health Center	October 26, 2023 – December 21, 2023
Fox Developmental Center	March 8, 2024 – May 21, 2024
Kiley Developmental Center	May 1, 2024 – June 4, 2024
Ludeman Developmental Center	March 20, 2024 – May 21, 2024
Mabley Developmental Center	April 4, 2024 – June 5, 2024
Madden Mental Health Center	November 16, 2023 – February 21, 2024
Murray Developmental Center	February 29, 2024 – April 30, 2024
Packard Mental Health Center	August 15, 2023 – December 1, 2023
Shapiro Developmental Center	February 15, 2024 – April 11, 2024

OIG began the site visit process by going to each facility and holding an entrance conference with the facility's administrative staff. OIG staff 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.

Prior to the site visit Exit Conference, OIG provided each facility with a draft site visit report. The draft report contained initial observations and recommendations, and OIG invited the facility to discuss any outstanding questions at the Exit Conference. During the Exit Conference, which was conducted via WebEx, OIG then asked the facility to submit any response or comments in writing within one week of the conclusion of the Exit Conference and included that information in the final report. In several cases, the facility was able to produce additional information that was not available prior to that time, and OIG's reports incorporated that information as appropriate.

OIG provided each facility with a formal report within sixty working days of the Exit Conference. As OIG has done in past years, upon receipt of the final report, OIG asked each facility to submit to OIG a written plan/status update to address the report's recommendations within sixty days of the site visit's completion.

Summary of Recommendations

In FY24, OIG made 33 recommendations (18 for mental health facilities and 15 for developmental facilities).¹⁰ OIG found the following during the FY24 site visit process:

- At 12 of the 14 facilities (86%), Human Rights Committee (HRC) members were not fully trained and oriented to perform their duties on the HRC;
- At 7 of the 14 facilities (50%), there was no uniform method for the HRC to review complaints or concerns submitted by individuals, guardians, or other concerned parties;
- At 5 of the 14 facilities (36%), the HRC either did not meet at all or were not meeting regularly as a separate committee.

At three other facilities there was insufficient data to evaluate the FY23 site visit topic of the Sentinel Event Process. Therefore, OIG will re-evaluate this during the FY25 site visit.

Chapter 3: Additional FY24 Data

A. Reporting Allegations to OIG in a Timely Manner

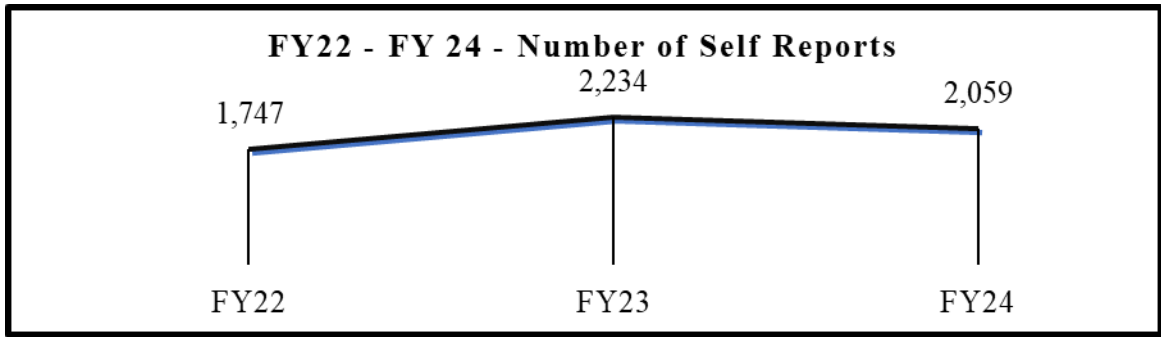
Any employee of a State-operated facility or community agency that falls under OIG's jurisdiction is a required reporter and must report an abuse or neglect allegation to OIG's Hotline within four hours of their initial discovery of the allegation. OIG refers to these types of reports as "self-reports." Allegations reported by anyone who is not a required reporter are called "complaints." Facilities and agencies generally train their staff on the four-hour 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, states the number of days each report was late, and provides the overall percentage of reports that were late. In FY24, OIG received 2,059 self-reported allegations of abuse and neglect, a 7.8% decrease from FY23.

¹⁰ There were 3 follow up recommendations at two facilities from prior FY site visits.



Late-Reporting

The percentage of late self-reports (i.e., reports of abuse, neglect, financial exploitation, and death¹¹ from facility or community agency employees) decreased slightly from 13.07% in FY23 to 11.89% in FY24¹². 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.

Fiscal Year	Late from Agencies		Late from Facilities		Total Late	Percent Late
	DD	MH	DD	MH		
	FY22	137	16	25		
FY23	195	27	35	35	292	13.07%
FY24	148	27	39	31	245	11.89%

B. OIG Caseloads

During FY24, OIG opened 4,059 cases, a 16% increase from FY23.¹³ The below tables reflect the number of cases OIG opened and completed from FY22 through FY24.¹⁴¹⁵

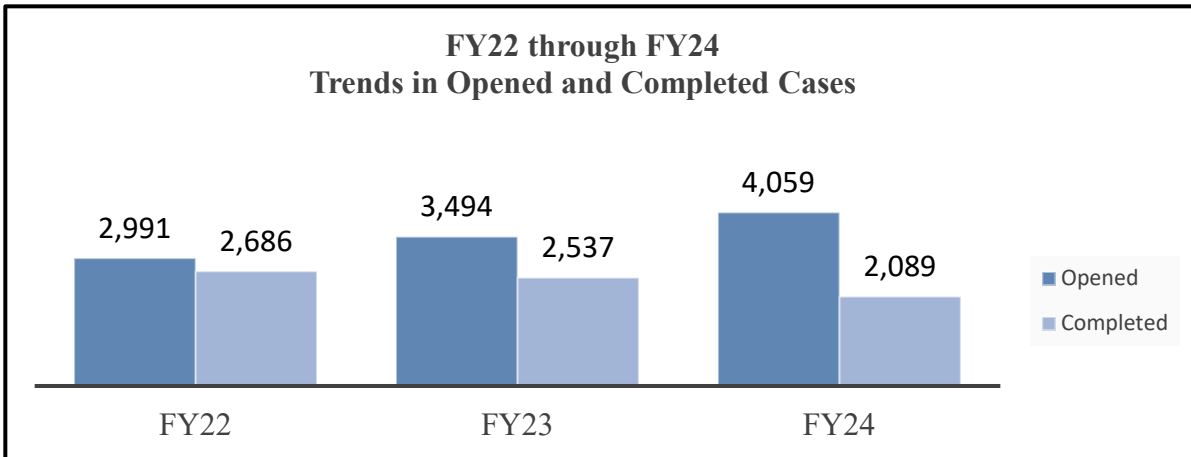
¹¹ Language changed to reflect that Self-Report cases do (and historically have) also included death and financial exploitation cases in these counts.

¹² Self-report numbers for FY22 and FY23 have been corrected to address unintentional data errors. Changes in total Self Reports were: -1 case in FY22 and -19 cases in FY23. As a result, late percentage for FY23 was also re-calculated.

¹³ Since FY22, Bureau caseload figures include completed death reviews.

¹⁴ The June 30, 2023 Caseload figures are, in some cases, slightly different from those reported in OIG’s FY23 Annual Report, likely due to database reclassifications or corrections that occurred during FY24.

¹⁵ FY22, FY23 and FY24 data was pulled using open and completed case data. The date a case is completed is more reflective of the timeliness of OIG’s work and does not include the 30 days OIG waits to enter the final date in the OIG database.



FY23 and FY24 Investigator Caseload Comparison By Bureau		
	Caseload as of June 30, 2023	Caseload as of June 30, 2024
Central	201	413
Cook	452	778
Metro	691	966
North	568	1,317
South	358	696
OIG	2,270	4,170

C. Timeliness of OIG’s Investigations

OIG’s directives provide that investigators are to submit investigative case reports within 60 working days of their assignment. However, for a variety of reasons, it is not uncommon for OIG investigations to extend beyond 60 days. Most notably, some cases are complex and require interviews of numerous staff and individuals, the issuance of subpoenas, the review of hundreds 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, investigative caseloads (cases per investigator), on average, remain higher than OIG would like. 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 available, 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 top priority for OIG to keep investigator caseloads at reasonable levels.

As the below table reflects, for the past three years, OIG’s average time to complete an investigation has remained above 60 days.¹⁶ During FY24, the average time it took to complete a case increased to 166.90 from 126.87 days in FY23.

Cases Completed Within and Over 60 Days FY22 through FY24		
Fiscal Year	Cases Completed Within 60 Days	Cases Completed Over 60 Days
FY22	51%	49%
	(1,367)	(1,372)
FY23	37%	63%
	(943)	(1,592)
FY24	25%	75%
	(522)	(1,569)

FY24 Cases Completed Within and Over 60 Days Community Agency Cases vs. Facility Cases			
Timeliness of Community Agency Cases		Timeliness of Facility Cases	
Cases Completed within 60 Days	Cases Completed Over 60 Days	Cases Completed within 60 Days	Cases Completed Over 60 Days
20% (243)	80% (993)	33% (279)	67% (574)

¹⁶ When the Illinois State Police (ISP) or local law enforcement (LLE) accept 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.

FY22 through FY24 Average Days for Case Completion		
Fiscal Year	Average Total Days	Average OIG Days
FY22	129.46	123.08
FY23	146.76	141.88
FY24	158.52	157.15

FY24 Average Days for Case Completion Community Agency Cases vs. Facility Cases			
Community Cases		Facility Cases	
Average Total Days	Average OIG Days	Average Total Days	Average OIG Days
180.54	180.39	126.64	123.47

FY24 Average Days for Case Completion by Case Type	
Mental Abuse (Psych)	104.31
Mental Abuse - Verbal	115.54
Sexual Abuse	126.85
Physical Abuse	153.73
Death Report	184.77
Neglect	213.96
Financial Exploitation	132.40
Neglect - COVID	390.33
Death Report - COVID	222.67
Suicide	437.50

D. Facility Staffing Ratios

By law, OIG’s annual report must include facility census figures which include counts of the number of individuals receiving services in each facility and the ratios of individuals to direct care staff. IDHS calculates those ratios as of June 30, 2024, or the last day of FY24.

Below are the census figures and staffing ratios for each type of facility at the close of FY24. 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, 2024, which details the number of individuals in the facility on that day.

IDHS also uses the June 30, 2024, census figure to calculate the direct care staff to patient ratios. The number of direct care staff is counted in Full-Time Equivalents, which counts part-time staff as only a fraction of an FTE. That count, again as of June 30, 2024, is reflected in the fourth column of the tables.

IDHS Budget divides the June 30, 2024 direct care staff figures by the June 30, 2024 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, 2024)					
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 Individual Ratio
Alton MHC	238	43,159	125	165.00	1.32
Chester MHC	505	103,549	287	322.40	1.12
Chicago Read MHC	385	56,180	156	194.00	1.24
Choate MH & DC Total	361	91,253	223	410.70	1.84
Elgin MHC	948	151,465	418	429.10	1.03
Fox DC	77	25,495	68	132.00	1.94
Kiley DC	181	60,550	164	304.30	1.86
Ludeman DC	334	113,058	308	750.50	2.44
Mabley DC	118	41,131	110	157.40	1.43
Madden MHC	1,734	31,256	87	117.10	1.35
Murray DC	285	97,422	270	365.10	1.35
Packard MHC	314	49,009	144	194.80	1.35
Shapiro DC	502	171,072	472	836.60	1.77
Total DD Facilities	1,858	599,981	1,615	2,956.60	1.83

Total MH Facilities	4,124	434,618	1,217	1,422.40	1.17
Total DD and MH Facilities	5,982	1,034,599	2,832	4,379.00	1.55

E. Quality Care Board

The purpose of the Quality Care Board (“QCB” or the “Board”), which was authorized in 1992, is to “monitor and oversee [OIG’s] operations, policies and procedures.” *See* 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 who have mental illness or developmental disabilities. At least two members must either have a disability themselves or have a child with a disability. The members are not paid, but OIG may reimburse them for any costs related to travel.

The QCB members for FY24 were:

Saul Morse, Chairman
 Angela Hearts-Glass, Member
 Megan Norlin, Member
 Shirley Perez, Member
 Jae Jin Pak, Member
 Nancy Sage, Member
 Gregory Walkington, Member

The QCB held six meetings in FY24, all by teleconference. The meeting dates were as follows:

August 15, 2023
 October 17, 2023
 December 19, 2023
 February 20, 2024
 April 16, 2024
 June 18, 2024

F. Mortality Review Board

The purpose of the Mortality Review Board (“MRB” or “Board”), which was authorized in the Developmental Disability and Mental Health Safety Act, also known as Brian’s Law, is to develop an independent team of experts from the academic, private, and public sectors to examine all deaths at facilities and community agencies. *See* Developmental Disability and Mental Health Safety Act, 405 ILCS 82/1. The independent team is to review the following:

- cause and manner of the individual's death;
- review all actions taken by the facility, state agencies, or other entities to address the cause or causes of death of medical care and treatment;
- evaluate the means, if any, by which the death might have been prevented;
- report its observations and conclusions to the Secretary of Human Services and make recommendations that may help to reduce the number of unnecessary deaths;
- promote continuing education for professionals involved in investigating and preventing the unnecessary deaths of individuals under the care of a facility or community agency; and
- make specific recommendations to the Secretary of the Human Services concerning the prevention of unnecessary deaths of individuals under the care of facilities and community agencies, including changes in policies and practices that will prevent harm to individuals with disabilities, and the establishment of protocols for investigating the deaths of these individuals.

The MRB members for FY24 were as follows:

Continuing Members from FY23

- Dennis Beedle, MD, Chair
- Chris Helfrich, RN, Member
- Stacey Aschemann, Member
- Randy Malan, Member
- Anne Fitz, APN, Member

New Members during FY24

- Shane Burke, MD, Member
- Justin Spring, MD, Member
- Mary Keen, MD, Member
- Joyce Miller, MD, Member
- Scott Gershan, MD, Member

Departing Members during FY24

- Stephen Dinwiddie, Member
- Sarah Anderson MD, Member
- Fred Jones-Rosa MD, Member

The MRB held 4 meetings in FY24, all by teleconference, as follows:

January 15, 2025

April 16, 2025

July 16, 2025

October 15, 2025

Chapter 4: Areas of Advancement

During FY23, OIG made numerous modifications to its policies and procedures and proposed multiple statutory or regulatory changes, which include the following.

A. Cameras at DD State-Operated Facilities

In the Spring of 2023, after receiving a September 2022 request from then-Secretary Grace B. Hou, OIG completed an interview-based review of Choate Mental Health and Developmental Center (CMHDC) following a series of criminal indictments of CMHDC staff for abuse of individuals at CMHDC and several OIG investigations that raised concerns about abuse and neglect reporting and prevention at CMHDC. OIG made five recommendations, one being that CMHDC and DHS should explore all option for the installation of internal security cameras at the facility. To date, the policy for camera use has been finalized at each DD facility. The following progress has been made at DD facilities:

Security Camera Installation Status	
Choate DC	296 inside cameras and 39 outside cameras are wired and installed. The Choate camera project is in testing mode as not all planned areas are wired.
Fox DC	84 cameras are wired and 78 are installed. The Fox DC camera project is not in test mode yet.
Kiley DC	Wiring completed for 432 cameras. The cameras are not ordered or installed yet. The Kiley DC camera project is not in test mode yet.
Ludeman DC	Wiring in process for 326 camera lines. Additional 77 cameras are needed. The Ludeman DC camera project is not in test mode yet.
Mabley DC	Wiring completed. 78 cameras received. Cameras are being installed. The Mabley DC camera project is not in test mode yet.
Murray DC	Wiring in process. There will be 187 cameras. The Murray DC camera project is not in test mode yet.
Shapiro DC	Wiring in process. There will be 677 cameras. The Shapiro DC camera project is not in test mode yet.

During FY24, there were two cases that were referred to ISP/Division of Internal Investigations for investigation that had video footage of the allegations available due to the recently installed cameras.

2924-0163 – OIG received an anonymous complaint that an employee struck an unnamed individual while having a behavior. The accused employee has been indicted and the case is set for criminal trial this calendar year.

2924-0168 – A facility employee allegedly body slammed an individual to the ground and put a knee to the individual’s face. The accused employee has been indicted and arraignment is set for this calendar year.

OIG expects that camera footage will play an increasingly important role in OIG cases in FY25.

B. Material Obstruction of an Investigation as a HCWR-Reportable Finding

In the Fall of 2022, OIG submitted a legislative proposal seeking to amend 20 ILCS 1305/1-17(a), (m) and (s) to create a new Health Care Worker Registry (HCWR) reportable finding: Material Obstruction of an Investigation. Of great concern was that OIG regularly saw instances where facility or agency staff sought to protect each other from the consequences of their misconduct by remaining silent about what they witnessed or lying to protect their fellow employees. As a result of the legislative proposal, on June 9, 2023, Public Act 103-0076 was signed into law, which made Material Obstruction of an Investigation a HCWR-Reportable finding. Material Obstruction of An Investigation is defined as:

"the purposeful interference with an investigation of physical abuse, sexual abuse, mental abuse, neglect, or financial exploitation and includes, but is not limited to, the withholding or altering of documentation or recorded evidence; influencing, threatening, or impeding witness testimony; presenting untruthful information during an interview; failing to cooperate with an investigation conducted by the Office of the Inspector General. If an employee, following a criminal investigation of physical abuse, sexual abuse, mental abuse, neglect, or financial exploitation, is convicted of an offense that is factually predicated on the employee presenting untruthful information during the course of the investigation, that offense constitutes obstruction of an investigation. Obstruction of an investigation does not include: an employee's lawful exercising of his or her constitutional right against self-incrimination, an employee invoking his or her lawful rights to union representation as provided by a collective bargaining agreement or the Illinois Public Labor Relations Act, or a union representative's lawful activities providing representation under a collective bargaining agreement or the Illinois Public Labor Relations Act. Obstruction of an investigation is considered material when it could significantly impair an investigator's ability to gather all relevant facts. An employee shall not be placed on the Health Care Worker Registry for presenting untruthful information during an interview conducted by the Office of the Inspector General, unless, prior to the interview, the employee was provided with any previous signed statements he or she made during the course of the investigation."

In the Spring of 2024, OIG submitted a legislative proposal to Make Material Obstruction of an Investigation an OIG Allegation type, therefore requiring mandated reporters to call OIG within four hours of discovery of an employee purposefully interfering with an OIG investigation.

OIG believes the Material Obstruction of an Investigation finding will deter misconduct as employees will be aware that obstructing an OIG investigation could result in them not being able to work for any Health Care Employer in the state, as provided by the Healthcare Worker Background Check Act, 25 ILCS 46/15. As a result of this amendment, OIG is better positioned to ensure that perpetrators are not able to continue abusing some of the State's most vulnerable individuals.

Since Material Obstruction of an Investigation became a new OIG finding type, there have been two cases with Material Obstruction of an Investigation findings. Below is a summary of those cases:

1224-0364 - OIG's investigation revealed the accused took two individuals to an apartment complex and left them unsupervised with an unknown male Uber driver. While at the apartment complex, the accused entered a residence where they damaged property and a physical altercation ensued in which the accused was injured. The accused was subsequently arrested and taken to jail for Battery. During the investigation, the accused intentionally presented untruthful information to the agency and OIG, which significantly impaired the ability of the investigator to gather all relevant facts. After the incident, the accused provided false information to their agency about the incident. Then, the accused deliberately provided a false narrative to OIG regarding what transpired during the incident despite being shown their arrest record, specifically, by claiming the individuals were with them the entire time, there was no physical altercation, and they were never arrested.

1924-0051 – While the underlying allegation was determined to be unsubstantiated, OIG found that the accused materially obstructed the investigation by providing false information to the facility, e.g., denying they had communications with an individual from their personnel cell phone, as the facility initiated the preliminary steps of the OIG investigation as provided by 50.30(f).¹⁷ Then the accused changed their account during a union rebuttal to discipline, where the accused partially admitted to making a few phone calls to the individual, but still not to the extent as shown by the evidence. OIG's investigation determined that the accused made false statements to the facility and the false statements significantly impaired OIG's ability to gather all relevant facts.

C. Rule 50 Amendments

During FY24, OIG submitted for consideration proposed amendments to Rule 50. On June 9, 2023, Public Act 103-0076 was signed into law, which made Material Obstruction of an Investigation a new OIG finding type. OIG proposed the rulemaking to make Rule 50 consistent with this Public Act. On September 27, 2024, the amendments were adopted.

D. FY2024 Legislation – Reviews of Facilities and Community Agencies

On August 2, 2024, Public Act 103-0752 was signed into law. In the Spring of 2024, OIG submitted a legislative proposal seeking to amend 20 ILCS 1305/1-17 to give OIG authority to initiate reviews of facilities and agencies related to preventing, reporting, and investigating abuse, neglect, financial exploitation, and material obstruction of OIG investigations, in response to complaints or information gathered from investigations.

The Inspector General will issue a written report, setting forth its conclusion and recommendations, and the report will be distributed to the Secretary and the director of the facility or agency that was subject of the review. The facility or agency will then be required to submit a written response addressing the Inspector General's conclusions and recommendations and, in a concise and reasoned manner, the actions taken to: (i) protect the individual; (ii) prevent

¹⁷ 50.30(f) requires the facility to take certain preliminary steps after an allegation has been reported to OIG, including taking statements from the victim, witness, and accused.

recurrences; and (iii) eliminate the problems identified. This will help OIG take a system-focused, proactive approach toward preventing abuse and neglect of individuals.

E. New OIG Hotline Poster

During FY24, OIG updated its OIG Hotline poster to include the new finding type, Material Obstruction of an investigation. See Appendix C for the OIG Hotline poster in English and Spanish.

F. FY25 Proposed Legislation

During the FY25 Spring legislative session, OIG will introduce legislation which will allow OIG to provide the Illinois Department of Financial and Professional Regulation (IDFPR) the OIG investigative casefile, e.g., interview statements, medical records, upon written request, when a case will be substantiated against a person licensed by IDFPR. Rule 50 already states that OIG will provide IDFPR the Investigative Report when a case will be substantiated against a person licensed by IDFPR.

Chapter 5: Training and Certification Updates

A. OIG Staff Training

New Hire Training

OIG notes that OIG's classroom training for new hires includes instruction in the following areas:

- OIG History
- Applicable directives, rules, statutes
- Investigative skills and Interviewing
- Report Writing
- Appeals Rights and Testifying
- OIG Database
- Role of Medical Analysts
- Person Centered Planning

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 regular assessments to ensure the new probationary ISIs obtain all necessary investigative skills.

Annual 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's

investigations 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 FY24, OIG staff completed all necessary courses to meet these requirements, OIG used IDHS' OneNet system to initiate, implement and document OIG staff trainings. In FY24, OIG completed its process to convert new employee staff training from the OIG database to the DHS OneNet system.

AIG Training for Investigative Bureau Chiefs

During FY24, five senior management OIG staff attended the Association of Inspectors General 5-day training to become Certified Inspectors General Investigators. The training covered the following seven core competency areas:¹⁸

- The investigative process;
- Professional standards for conducting investigations;
- Ethics in investigations;
- Legal issues;
- Procurement fraud and computer crime;
- Investigative techniques;
- Working with auditors.

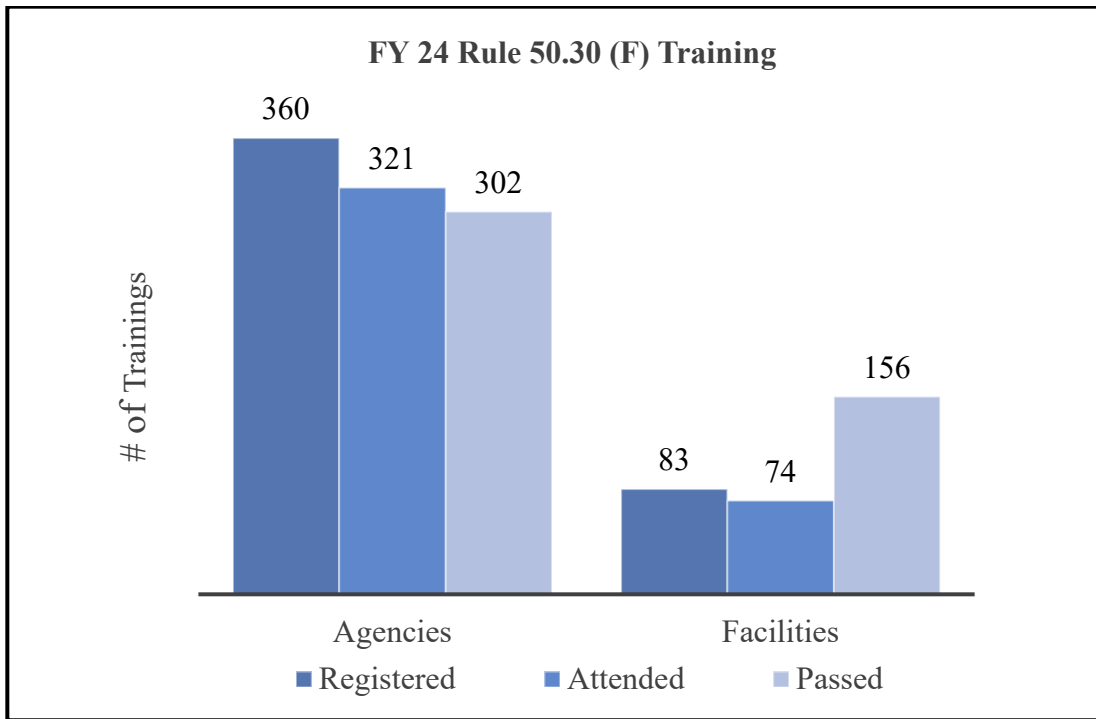
B. Training for Agencies and Facilities

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 statements from principles involved in the incident, and gathering basic documentation related to the incident.

OIG provides online training to help agencies and facilities carry out this important function. In FY24, 443 agency and facility staff registered for OIG's online 50.30(f) training, 395 attended the training and of those, 376 passed. To pass the training, the staff have to score 70% or better on a test. Roughly 81% of agency staff and 100% 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.

¹⁸ The AIG provides certified programs where participants receive instruction from highly qualified instructors in core competency areas. See the AIG website, [The Association of Inspectors General – Advancing Professionalism, Accountability & Integrity](#)



OIG Investigative Steps

OIG also provides an online “Investigative Steps” training for employees at IDHS’ Developmental and Mental Health Centers that provides instruction on interviewing and document/evidence collection. For a Facility employee to become a Facility Investigator (which allows them to play a more significant role in the initial response to an allegation, including conducting interviews instead of gathering statements), they must take the Investigative Steps training. During FY24, 64 facility staff registered for the training, 62 facility staff attended, and 62% who attended passed the test.

Rule 50 Training

During the fourth quarter of FY24, OIG began collecting the number of persons who were recorded as having been Rule 50 trained at their facility or agency. The purpose was to ensure staff who were registering for 50.30(f) or Investigative Steps had the required Rule 50 training prior to taking the other classes. During FY24, 363 distinct persons were recorded as having been Rule 50 trained at their facility or agency.

Chapter 6: Notable OIG Investigations

OIG’s work often results in significant criminal or administrative consequences for employees who engage in abuse, neglect, financial exploitation, or material obstruction of an investigation. Below are deidentified, narrative summaries of a small sample of the 246 cases OIG substantiated in FY24.¹⁷

2920-0097 – OIG substantiated a finding of physical and mental abuse where its investigation established that a facility employee struck an individual on the head while in the kitchen, washing

their hands. OIG's investigation further established that the employee mentally abused the individual when the employee inappropriately threw the individual's dinner plate in the trash in an apparent attempt to punish the individual for either eating too slowly or for stating "Do not hit me" to the accused. OIG recommended training with respect to the reporting of misconduct and the implementation of policies and procedures to ensure staff are not fearful of reporting misconduct because of implicit or explicit threats of retribution, as one employee did not report the incident because of fear of losing their job.

The facility's response to the investigation included, but was not limited to, the following: (1) staff received significant training on many topics including, rights of individuals, dignity and respect of individuals, restriction of rights of individuals, reporting abuse to OIG, ISP investigations, mandated reporting, code of silence, failure to report, and retaliation; (2) the facility revised policy and forms to improve documentation, educated residents on identification of abuse, hired additional security staff, worked on installing cameras, conducted a safety questionnaire, followed up with a safety summit, and conducted ICPN trainings; and (3) new employees would receive training regarding retaliation in an effort to prevent new staff from being fearful of reporting misconduct. After OIG completed its investigation, the employee resigned their position. 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.

2923-0077 – OIG substantiated a finding of physical and mental abuse where its investigation established that two facility employees yelled at an individual and threatened to place the individual into restraints, even though the individual was not engaging in behavior that warranted the use of restraints. The employees' threats and yelling escalated the individual's conduct and resulted in the individual experiencing emotional distress. The employees then dragged the individual a short distance. The facility's response to the investigation was that both employees were dismissed. After OIG completed its investigation, OIG reported the employees' names and OIG's findings to the HCWR, rendering the employees' ineligible to be employed by an Illinois health care employer.

2921-0212 - OIG substantiated a finding of physical abuse where its investigation established that a facility employee grabbed an individual's hair so tightly that the individual could not move their head, pushed them by their head, and punched them in the back of their head. The employee was indicted on two felonies and one misdemeanor and pled guilty in court to a charge of Disorderly Conduct. The facility's response to the investigation was to discharge the employee. OIG has begun the process to report the name and the finding to the HCWR, which would render the employee ineligible to be employed by an Illinois health care employer.

2923-0102 – OIG substantiated a finding of neglect when where its investigation established that a facility employee failed to provide adequate supervision for an individual when the individual was attacked in their bedroom by multiple peers and was injured. The facility's response to the investigation was that the employee was terminated, and two employees received retraining regarding OIG Rule 50.

5823-0083 – OIG substantiated a finding of physical abuse when a facility employee pushed an individual in the chest in the hallway. OIG recommended that the facility consider placing surveillance cameras in common areas to aid future investigations. The facility is in the process of wiring for cameras. The facility's response to the investigation was to initiate disciplinary action, which is pending. OIG has begun the process to report the name and the finding to the HCWR, which would render the employee ineligible to be employed by an Illinois health care employer.

5823-0084 - OIG substantiated a finding of physical abuse where its investigation established that a facility employee grabbed an individual by the wrist and slammed the individual to the floor. OIG recommended that the facility consider installing surveillance cameras in the common areas of the unit because a camera in the hallway may have provided conclusive evidence to confirm or refute the allegation. The facility is in the process of wring for cameras. The facilities response to the investigation was to initiate disciplinary action, which is pending. OIG has begun the process to report the name and the finding to the HCWR, which would render the employee ineligible to be employed by an Illinois health care employer.

5823-0088 – OIG established a finding of neglect where its investigation established that a facility trainee provided an individual with a vape pen to smoke/ingest a substance that contained cannabidiol (CBD) and/or tetrahydrocannabinol (THC). The facility’s response to the investigation was that the trainee was discharged.

6623-0021 – OIG established a finding of neglect where its investigation established that two facility employees neglected two individuals when one of the individuals with a known propensity for aggression was allowed to approach a second individual. After a physical altercation, the two employees failed to have a nurse evaluate the individual who was attacked when he resorted to crawling instead of walking. A subsequent medical evaluation determined the individual suffered a fracture to their hip because of the incident. OIG recommended the two staff be retrained on the responsibilities of STAs and to immediately notify medical personnel when a reasonable person would suspect a person was injured. OIG also recommended the facility codify the established practice of keeping an individual who visits another module separated from those normally housed on the unit. The facility’s response to the investigation was that both employees served 5-day suspensions and were to receive training.

1320-0035 – OIG established a finding of sexual abuse where its investigation established that a community agency employee sexually abused an individual while alone on the bus during transport home from community day services. The employee pushed their hand in an individual’s shirt, through the sleeve opening, under the bra strap, and touched their breast. The employee pled guilty to Criminal Sexual Abuse of the individual. The agency’s response to the investigation was that the employee was terminated from the agency and cameras were installed in all agency vehicles that transport individuals. In addition, all DSPs, including drivers were retrained on Rule 50 and would be trained on an annual basis. Finally, all transportation routes now are created and approved by a manger. After OIG completed its investigation, 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.

1318-0424– OIG established a finding of neglect where its investigation established that an agency employee failed to conduct required bed checks every 30 minutes on an individual after 2:30 a.m. At some point after that, the individual suffered a serious change in their medical condition. There was some evidence that the individual had been deceased for some time prior to discovery. The agency’s response to the investigation was that the employee was no longer employed with the agency and was ineligible for re-hire.

6623-0076 - OIG substantiated a finding of physical abuse where its investigation established that a facility employee struck an individual in the head with their fist (at least once, and perhaps five or six more times) because the individual was biting the employee’s arm. OIG identified a mitigating factor that the individual was biting the staff person at the time of the physical abuse.

OIG recommended that the facility address the accused employee and a second employee's failure to adhere to the facility policy regarding approaching extremely agitated patients in rooms on modules.

The facility's response to the investigation was that disciplinary action was initiated against the first employee, which was pending at the end of FY24. The facility counseled and retrained the second employee on the facility policy regarding approaching extremely agitated patients in rooms on modules.

6623-0098 – OIG established a finding of neglect where its investigation established that a facility employee failed to appropriately provide 1:1 supervision, which allowed an individual to obtain a pen and crayons from another individual and engaged in their known self-injurious behavior of swallowing the crayons and inserting the pen deeply into their urethra, which required medical attention. OIG identified mitigating factors in that the employee was near the end of their second double shift in a row and noted they were tired, as fatigue could have played a role in their lack of attentiveness. Also, the employee did not normally work on the individual's unit and was unfamiliar with the individual's capacity for manipulation and potential for severe SIB.

The facility's response to the investigation was that the employee was suspended for 5 days. The facility also updated its special observation policy and retrained staff, and indicated a new form would be created to give staff a better understanding of what behaviors to look for when an individual is placed on special observation.

1223-0485 – OIG established a finding of sexual abuse and neglect where its investigation established that an agency employee sent numerous text messages to an individual that were sexual in nature and engaged in sexual relations with the individual on at least one occasion. The employee also provided the individual with illegal narcotics and prescription drugs, which they used together. The agency's response to the investigation was that the employee was discharged. 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.

1622-0183 – OIG established a finding of egregious neglect where its investigation established that an agency employee failed to ensure an individual received prompt medication attention after the individual displayed COVID symptoms and was so weak that he was unable to walk on his own, had no balance, and needed assistance when placed in the agency vehicle. Rather than taking the individual to the hospital, the employee drove the individual and four other individuals over 20 miles to a Walgreens to get them tested for COVID. The employee left the individuals unattended in a cold vehicle while he went inside the Walgreens. Once the employee returned to the vehicle and found the individual unresponsive, the employee stopped for coffee before driving over 20 miles back to a hospital, rather than rushing to the nearest hospital or calling 911. Hospital employees observed the individual to be exhibiting rigor mortis, which indicated the individual had been deceased for hours and either had been dead when the individuals were made to load them in the car or had died in the car with other individuals present. The agency ceased operations on March 3, 2022. OIG has begun the process to report the name and the finding to the HCWR, which would render the employee ineligible to be employed by an Illinois health care employer.

1622-0184 – OIG established a finding of neglect where its investigation established that an agency employee failed to provide adequate medical care, personal care, and maintenance when the individuals exhibited cold and flu like symptoms/COVID symptoms for over one week. The agency ceased operations on March 3, 2022.

1624-0221 – OIG established a finding of neglect where its investigation established that an agency employee failed to ensure that all passengers have exited the vehicle at the end of each trip. As a result, an individual, who did not have approval for alone time in the community, was left alone and unsupervised inside an agency vehicle in cold temperatures for over two hours. The agency’s response to the investigation was that the employee would receive a final written warning and would be retrained in the vehicle operating policy and procedures.

1024-0173 – OIG established a finding of neglect where its investigation established that an agency employee tasked two individuals with the supervision of a third individual, who was experiencing suicidal ideation. The agency employee failed to complete a safety plan, contact a supervisor, or call 911 for the individual with suicidal ideations, which placed the individual’s health and safety at substantial risk of injury, harm, or death. The agency employee failed to provide the two individuals that they placed responsibility on for supervising the individual with suicidal ideations with adequate personal care as the individuals’ expressed anxiety or worry that the individual would harm themselves while in their care. The agency’s response was to terminate the employee and conduct refresher training on OIG requirements.

4522-0003 – OIG established a finding of physical abuse where its investigation established that a facility employee “snatched” the telephone away from an individual’s hands and pushed the individual. The individual incurred superficial cuts on their head. The facilities response to the investigation was to initiate disciplinary action, which is pending. OIG has begun the process to report the name and the finding to the HCWR, which would render the employee ineligible to be employed by an Illinois health care employer.

Chapter 7: Closing Remarks

A. IDHS OIG Chief Administrative Officer Jesse Escarpita

FY24 was a very busy year for OIG on the administrative front. OIG saw the hiring of dozens of new staff and we were able to fill strategic hires that were created in FY23. Among the strategic hires filled in FY24 were the North Assistant Deputy Inspector General, Office Administrator IV-Central, a second Intake/Hotline Investigative Team Leader, and multiple office associates. These positions, which range from leadership to frontline administrative roles, have allowed OIG to carry out its investigative operations more efficiently and has allowed OIG to better manage the high volume of work the agency receives.

With the increase in hiring OIG experienced in FY24, OIG’s administrative team was able to procure additional office space to accommodate new staff. Though State office space is severely limited throughout Illinois, OIG worked with DHS Business Services to find office space in Marion County and in Chicago. In addition, OIG has been working to maximize our existing office space by adding to our offices at Elgin MH and Packard MH and through increased use of office hoteling.

In addition to progress in hiring, in FY24, OIG successfully completed its annual FY24 site visits, which focused on facilities’ Human Rights Committees. During the site visit, OIG found that multiple DD and MH facilities were failing to fully staff their Human Rights Committee, as required. In addition, various facility Human Rights Committees were failing to meet on a

consistent basis and were therefore failing to review human rights complaints. OIG is hopeful that the FY24 site visit findings will lead to functional process improvements at the DD and MH facilities that will benefit individuals.

Although OIG is proud to highlight its FY24 administrative successes, significant obstacles remain. The pace of hiring continues to be an issue for OIG's operations. Although we saw dozens of new hires in FY24, many of these vacancies were backlogged from the prior year or more. Despite reaching the highest level of full-time employees in my time with OIG, the agency is still severely understaffed. The current approved headcount for OIG is simply insufficient given the volume of work the agency receives statewide. In addition, accommodating new hires in the Southern region has proven challenging for OIG, as existing office space is severely limited. OIG will continue to work with DHS to identify potential office space in the southern region.

Looking into FY25, OIG sees reasons for optimism, as we have identified new opportunities for improvement that, if executed, will enhance our operations in the years to come. After the successful creation of the new positions in FY24, OIG began the process of creating additional positions that we believe will further improve OIG investigative operations and meet the growing demands of the agency. To that end, OIG is excited that its approved headcount increased from 89 in FY24 to 99 in FY25.

OIG is also procuring additional tools to assist OIG investigators in their operations. Such tools include an online legal investigative research application called CLEAR and an investigative report generation tool through DocuSign CLM.

B. Acting Inspector General Charles Wright

In FY25, OIG will continue to push for additional headcount to meet its staffing needs. To ensure that newly hired staff are prepared and remain current in the latest in investigative practices, OIG is in the process of hiring two trainers to help revamp OIG's training curriculum, identify external trainings, and train new staff. OIG also expects the trainers will conduct intermittent trainings for agency and facility staff. Furthermore, given our growing investigative staff, OIG is in the process of creating new supervisory positions to ensure appropriate supervision and maintain case report quality.

In FY25, OIG also looks forward to leveraging technology to create new efficiencies. OIG is currently working on a project in collaboration with DocuSign CLM to develop a report-generating platform that will automate some of OIG's case report writing and review process, which should increase productivity and help with timeliness. The project is expected to be finished sometime in FY25. OIG is also nearing the end of the development of its new web-based database, which, barring unforeseen delays, should be completed in the early months of FY26.

As always, OIG's mission to protect individuals from abuse and neglect propels us forward, even through challenges and setbacks. I am hopeful that FY25 will bring us one step closer to fully embodying our mission.

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 Act;
 - (ii) a life care facility, as defined in the Life Care Facilities Act;
 - (iii) a long-term care facility;
 - (iv) a home health agency, home services agency, or home nursing agency as defined in the Home Health, Home Services, and Home Nursing Agency Licensing Act;
 - (v) a hospice care program or volunteer hospice program, as defined in the Hospice Program Licensing Act;
 - (vi) a hospital, as defined in the Hospital Licensing Act;
 - (vii) (blank);
 - (viii) a nurse agency, as defined in the Nurse Agency Licensing Act;
 - (ix) a respite care provider, as defined in the Respite Program Act;
 - (ix-a) an establishment licensed under the Assisted Living and Shared Housing Act;
 - (x) a supportive living program, as defined in the Illinois Public Aid Code;
 - (xi) early childhood intervention programs as described in 59 Ill. Adm. Code 121;
 - (xii) the University of Illinois Hospital, Chicago;
 - (xiii) programs funded by the Department on Aging through the Community Care Program;
 - (xiv) programs certified to participate in the Supportive Living Program authorized pursuant to Section 5-5.01a of the Illinois Public Aid Code;
 - (xv) programs listed by the Emergency Medical Services (EMS) Systems Act as Freestanding Emergency Centers;
 - (xvi) locations licensed under the Alternative Health Care Delivery Act;
- (2) a day training program certified by the Department of Human Services;
- (3) a community integrated living arrangement operated by a community mental health and developmental service agency, as defined in the Community-Integrated Living Arrangements Licensing and Certification Act; or
- (4) the State Long Term Care Ombudsman Program, including any regional long term care ombudsman programs under Section 4.04 of the Illinois Act on the Aging, only for the purpose of securing background checks.”

Mental Health and Developmental Disabilities Administrative Act

20 ILCS 1705/7.3

Sec. 7.3. Health Care Worker Registry. The Department shall require that no facility, service agency, or support agency providing mental health or developmental disability services that is licensed, certified, operated, or funded by the Department shall employ a person, in any capacity, who is identified by the Health Care Worker Registry as having been the subject of a substantiated finding of physical abuse, sexual abuse, financial exploitation, egregious neglect, or material obstruction of an investigation. 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 physical abuse, sexual abuse, financial exploitation, egregious neglect, or material obstruction of an investigation is prohibited from any involvement in any capacity with the provision of Department funded mental health or developmental disability services. The Department shall establish and maintain the rules that are necessary or appropriate to effectuate the intent of this Section. The provisions of this Section shall not apply to any facility, service agency, or support agency licensed or certified by a State agency other than the Department, unless operated by the Department of Human Services. (Source: P.A. 103-76, eff. 6-9-23.)

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:

Physical Abuse

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

Sexual Abuse

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

Sexually Explicit Images

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

Financial Exploitation

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

Mental Abuse

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

Neglect

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

Egregious Neglect

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

Material Obstruction of an Investigation

"Material obstruction of an investigation" means the purposeful interference with an investigation of physical abuse, sexual abuse, mental abuse, neglect, or financial exploitation and includes, but is not limited to, the withholding or altering of documentation or recorded evidence; influencing, threatening, or impeding witness testimony; presenting untruthful information during an interview; failing to cooperate with an investigation conducted by the Office of the Inspector General. If an employee, following a criminal investigation of physical abuse, sexual abuse, mental abuse, neglect, or financial exploitation, is convicted of an offense that is factually predicated on the employee presenting untruthful information during the course of the investigation, that offense constitutes obstruction of an investigation. Obstruction of an investigation does not include: an employee's lawful exercising of his or her constitutional right against self-incrimination, an employee invoking his or her lawful rights to union representation as provided by a collective bargaining agreement or the Illinois Public Labor Relations Act, or a union representative's lawful activities providing representation under a collective bargaining agreement or the Illinois Public Labor Relations Act. Obstruction of an investigation is considered material when it could significantly impair an investigator's ability to gather all relevant facts. An employee shall not be placed on the Health Care Worker Registry for presenting untruthful information during an interview conducted by the Office of the Inspector General, unless, prior to the interview, the employee was provided with any previous signed statements he or she made during the course of the investigation.

APPENDIX C - OIG Hotline Poster

REPORT ABUSE AND NEGLECT

The Department of Human Services OIG investigates

NEGLECT,

PHYSICAL ABUSE,

MENTAL ABUSE,

SEXUAL ABUSE, and

FINANCIAL EXPLOITATION

If you or someone you know has been abused or neglected, call the OIG Hotline at

1-800-368-1463

Obstructing an OIG investigation is against the law and could result in being banned from working as a health care worker in Illinois.

(20 ILCS 1305/1-17(s))

INFORMAR ABUSO Y NEGLECTO

El Departamento de Servicios Humanos OIG investiga

NEGLECTO,

ABUSO FÍSICO,

ABUSO MENTAL,

ABUSO SEXUAL, y

EXPLOTACIÓN FINANCIERA

Si usted o alguien que conoce ha sido abusado o descuidado, llame a la línea de la OIG al

1-800-368-1463

Obstruir una investigación de OIG es ilegal y podría resultar en ser prohibido de trabajar como trabajador de atención médica en Illinois.

(20 ILCS 1305/ 1-17(s))



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