



JB Pritzker, Governor

Dulce M. Quintero, Secretary

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DATE: December 10, 2025

MEMORANDUM

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

FROM: Dulce Quintero *Dulce M. Quintero*
Secretary *by Steves*
Illinois Department of Human Services

SUBJECT: IDHS OIG FY25 Annual Report

The Illinois Department of Human Services respectfully submits the IDHS OIG FY25 Annual Report on behalf of the Office of the Inspector General in order to fulfill the requirements set forth in 20 ILCS 1305/1-17(v).

If you have any questions or comments, please contact C. Thor Martin, Acting Inspector General, at (773) 835-5664.

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

FY25 Annual Report



December 10, 2025

To Governor Pritzker and Members of the Illinois General Assembly:

In FY25, OIG continued to build upon staffing increases made from previous years. OIG increased its staff by 28%, from 89 employees to 114 at the close of FY25. The continued training and growth of that staff is essential to OIG meeting its mandate of timely and thorough investigations of abuse and neglect. Last year's Annual Report suggested a head count of 120 to meet all of OIG's obligations of investigating cases, conducting site visits and program reviews – along with staffing the 24/7 OIG Hotline and conducting “Rule 50” trainings for persons who work with individuals receiving mental health or developmental disabilities services. This period, OIG will approach its targeted headcount as it continues to fill current vacancies. We are excited to see the impact that such staff can make when they are fully trained. OIG also continually evaluates whether our current staffing is sufficient to do the ever-increasing work of investigating abuse and neglect of some of this State's most vulnerable individuals.

In a trend that has remained consistent since FY22, the number of complaints that OIG receives annually continues to increase. In FY25, OIG's intake calls rose from 15,366 to 16,877. This reflects another double-digit year over year increase of roughly 10% from FY24 and a near doubling (90%) in complaints since FY21. Of those calls, 4,275 cases were opened for review. While this is only an increase of 5% from FY24, the opened cases do not reflect the significant expansion of reportable referred intakes (476) in the latter half of FY25. These reportable referred intakes are allegations that would otherwise have been opened OIG investigations of simple (non-egregious) neglect, mental abuse, and *deminimus* financial exploitation. These are allegations that our State-operated facilities and community agencies were given authority to administratively address under 59 Ill. Admin. Code 50.30(e)(4). In FY25, OIG implemented reportable referred intakes with facilities. Despite this valuable tool to focus limited resources on the most serious allegations of abuse and neglect, the OIG's opened investigations in FY25 were an 83% increase from FY21.

An OIG investigator has an annual performance objective of 72 completed investigations a year. With 60 fully-trained field investigators working those cases at the expected performance levels, OIG strives to close 4320 cases a year. However, the current staffing level does not adequately address the immense backlog of cases that accrued during the acute staffing shortages of FY20 to FY23 and the year-over-year, double-digit increases in opened cases and intake calls. At the close of FY 25, 6,173 cases remained open, with 3,006 open longer than 1 year. Later in this report, we describe the efforts we have undertaken to reduce the weight of that backlog.

During FY25, OIG completed 3,148 cases - which represents a 55% increase in case completions over FY24. Cases completed within 60 working days increased by 40%. However, despite this improvement, OIG's timeliness rate – the percentage of cases completed within 60 days – stood at only 23% due to inexperienced investigators, staff turnover, and the continued weight of older cases that must be completed. The number of substantiated findings by OIG against accused employees were 381 (136 findings of abuse, including mental abuse, 218 findings of neglect, 3 findings of egregious neglect, 18 findings of financial exploitation, and 6 findings of material obstruction of an investigation).

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. In early FY25, that legislation was passed and in the 3rd Quarter of FY25 a new OIG staff member was hired to build that capacity. OIG continues to identify protocols for that review and works diligently towards programmatic reviews of agencies and facilities based on allegation trends.

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 neglects and, in some cases, exonerate falsely accused staff. Multiple factors have slowed the implementation of cameras at SODCs. According to the Division of Developmental Disabilities (DDD), cameras are now installed in all SODCs. However, at Choate and Fox, the cameras are only live in a test mode. At all other SODCs, the cameras are only installed and are not yet in test mode. The presence of video has been invaluable in identifying safety concerns that may not have been accurately reported initially both by staff and non-staff.

On a personal note, I was happy to join the Office of Inspector General in March of 2025. I was so impressed to find such a dedicated and purpose driven team of investigators, staff and leaders committed to uncovering abuse and neglect of individuals. I am honored to work alongside all of OIG. I have also been happy to find a collaborative spirit with stakeholders such as IDHS, IDPH and advocacy groups where our missions align to prevent abuse and neglect.

Sincerely,

A handwritten signature in black ink, appearing to read 'C. Thor Martin', is written over a light blue rectangular background.

C. Thor Martin
Acting Inspector General

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Chapter 1: Summary of OIG’s FY25 Data

A. Notable FY25 Data

The FY25 data demonstrates that OIG continues to experience a significant increase in Intake calls and opened investigations. Most notably:

- OIG’s Intake Bureau processed 16,877 calls, which is a 10% increase over FY24, and a startling 91% increase from FY21.
- OIG opened 4,275 investigations of abuse or neglect (including death reports), which is a 5% increase over FY24 – even with the referral of low-level investigations to the facilities under 59 Ill. Admin. Code 50.30(f).
- OIG’s cases resulted in 381 findings against accused employees (136 findings of abuse and 218 findings of neglect, 3 findings of egregious neglect, 18 findings of financial exploitation, and 6 findings of material obstruction of an investigation).
- OIG reported the names of 57 employees (included 65 substantiated findings) to the Department of Public Health’s Health Care Worker Registry (HCWR) - 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 FY25 metrics, *see infra* Chapters 2 & 3.

B. Hiring Accomplishments and Challenges

During FY25, 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 89 full-time employees (FTE) as of June 30, 2024 to 114 FTE as of June 30, 2025, a 28% increase.

During FY25, OIG hired 49 staff, the positions listed below:

Position	# of Hires
Internal Security Investigator 2	34
Investigative Team Leader	3
Office Associate	3
Trainers	2
Deputy Inspector General	1
Bureau Chief	1
Clinical Coordinator	1
Data Manager	1
Senior Compliance Analyst	1
Executive 1	1
Office Associate VI	1
Total	49

During FY25, OIG had the following attrition:

Reason for Leaving	# of Staff
Resigned	8
Returned to Prior State Position	7
Transfer	5
Retirement	4
Total	24

Additionally, as of June 30, 2025, OIG had the following 7 positions at various stages of the hiring process.

Position	# Pending
Internal Security Investigator 2	4
Inspector General	1
Assistant Deputy Inspector General	1
Office Associate	1
Total	7

Although a number of positions have been filled, unfortunately, delays in State hiring during FY23 and FY24 continued to impact OIG operations in FY25. For example, over half of the positions that were filled in FY25 (49%) took 7 months or longer to fill, as illustrated below. OIG continues to work with IDHS to improve the timeliness of this process and is encouraged by recent developments in the area of new hires.

# of Months	# of Hires
14 months	2
13 months	2
12 months	5
11 months	3
9 months	3
8 months	4
7 months	5

Chapter 2: OIG’s FY25 in Numbers

A. OIG Hotline Calls and Referrals

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 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.

During FY25, the OIG’s Intake Bureau processed 16,877 calls, as reflected in the below chart, a 10% increase over FY24, and a 91% increase since FY21.^{1 2}

OIG Intake Bureau Processed Calls FY21-FY25		
Year	# of Calls	Annual % Change
FY21	8,852	3% Increase
FY22	9,944	12% Increase
FY23	12,386	25% Increase
FY24	15,366	24% Increase
FY25	16,877	10% Increase

As background, in FY22 and FY23, OIG’s Intake Bureau was staffed by a Bureau Chief, one Investigative Team Leader, and six Intake Investigators. The steady upward trend of 24% volume from FY23 through FY24 necessitated the addition of four more Intake Investigator positions. This resulted in a 40% increase in Intake Investigators in FY25 and the addition of one Investigative Team Leader at the Hotline. Along with increased intake came the need for an Office Associate to support administrative processes.

By fully staffing and supporting the administrative duties of the Hotline, OIG was able to assess call data and redistribute Intake Investigators to cover a high volume of calls. OIG posted and filled the four new positions at those times. This change resulted in Intake Investigator coverage

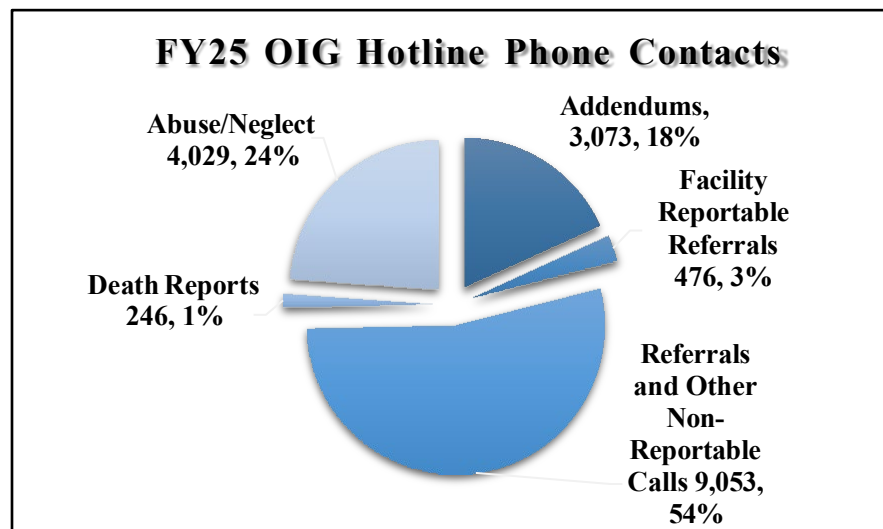
¹ During FY25, OIG referred 476 Facility Reportable Referrals to facilities. Rule 50 (59 Ill. Adm. Code 50.30) provides that a reportable allegation can be referred to a facility or agency when the primary facts relevant to the allegation have already been identified and additional investigative work 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.

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

of calls from 7:30 a.m. through 6:00 p.m. and 7:30 p.m. to 11:00 p.m. with additional staff covering the peak hours for call volume from 9:00 a.m. through 6:00 p.m.³

Another positive outcome of increasing staff by 40% is realized in the volume of calls Hotline staff are now able to answer “live” as opposed to calling complainants back from messages taken by an answering service. In FY25, the Hotline more than doubled their ability to answer “live calls,” going from 21% to 55%. This accomplishment was only achieved in the last quarter of FY25, when all new hires completed a 16-week training plan.

As the Hotline has leveraged data to inform needs and practice, it also began a transition to the use of DocuSign to track intake assignment and completion. Utilizing technology in this regard enabled the hotline to monitor and oversee intake assignment, intake type, Intake Investigator caseloads, and the timely completion of reports. Transitioning from a manual process to technology has resulted in the efficient use of time by Intake Investigators and supervisors and sets the stage for improved ability to ensure optimal performance of staff.



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 FY25, OIG had 5,122 referrals. The following table reflects the recipients of these calls:

Referral Location	Total Referred	%
Local Community Agency or Facility	1,699	33.2%
Illinois Department of Public Health	320	6.2%
Illinois Department on Aging	115	2.2%
Illinois Department of Healthcare and Family Services	105	2.0%
Illinois Department of Children and Family Services	55	1.1%

³ OIG has an answering service picking-up calls during the times that the Hotline is not fully staffed.

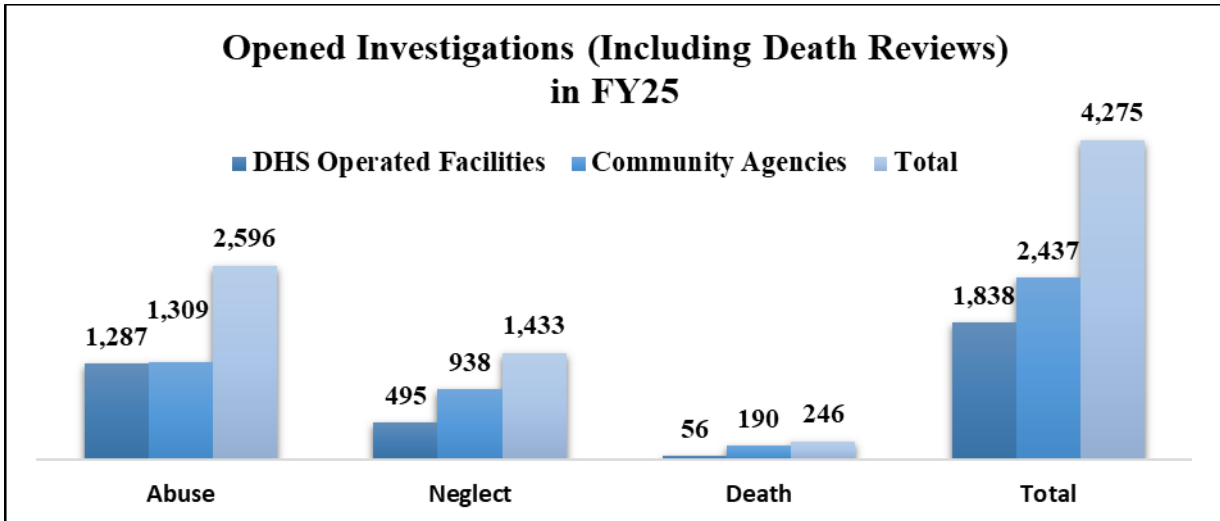
Referral Location	Total Referred	%
DHS Division of Rehabilitation Services	55	1.1%
DHS Bureau of Accreditation, Licensure & Certification /Bureau of Pharmacy and Clinical Support Services	52	1.0%
Law Enforcement	46	0.9%
Office of Executive Inspector General	43	0.8%
DHS Substance Use Prevention & Recovery	14	0.3%
DHS Division of Behavioral Health and Recovery (formerly Division of Mental Health)	13	0.3%
Illinois Department of Financial and Professional Regulation	5	0.1%
DHS Division of Developmental Disabilities	3	0.1%
Other	2,597	50.7%
Total Referred	5,122	

B. Opened Investigations (Including Death Reviews)

During FY25, OIG opened a total of 4,275 abuse or neglect investigations (including death reviews), 216 more than in FY24, or 5%, and an 83% increase from FY2021.

Opened Investigations (Including Death Reviews) FY21-FY25		
Year	# of Opened Investigations (Including Death Reviews)	Annual % Change
FY21	2,333	16% Decrease
FY22	2,991	28% Increase
FY23	3,494	16% Increase
FY24	4,059	16% Increase
FY25	4,275	5% Increase⁴

⁴ There were 476 reportable referred intakes during FY25. Reportable Referred Intakes do not count as opened investigations. Had this number been counted in opened investigations, there would have been a 17% increase in total opened investigations over FY24.



- Opened abuse investigations pertaining to IDHS-operated facilities and community agencies increased from 2,546 in FY24 to 2,596 in FY25, or 2%.
- Opened financial exploitation investigations increased by 22, or 16% from FY24 to FY25.
- Opened neglect investigations pertaining to IDHS-operated facilities and community agencies increased by 147 from FY24 to FY25, or 11%.

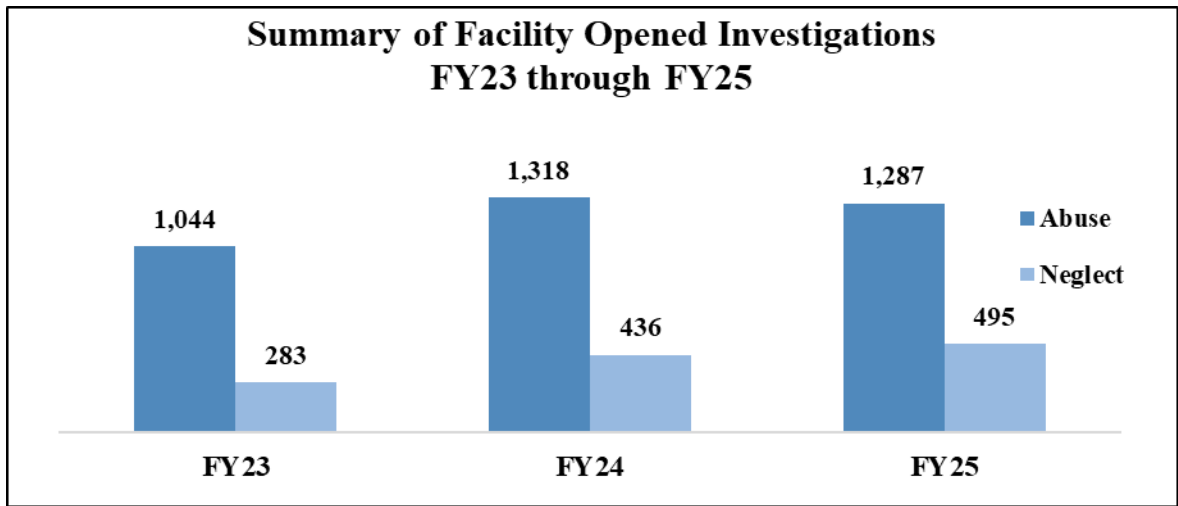
The following tables provide a detailed breakdown of the opened investigations in FY25 by type and location.

Facilities

During FY25, OIG opened 1,782 abuse or neglect investigations pertaining to the IDHS-operated facilities, an increase of 1.6% from FY24.⁵

- 1,287 of the 1,782 opened facility investigations were for abuse (which included 66 opened investigations of financial exploitation).
- Abuse opened investigations accounted for 70% of the total opened investigations at facilities, which is 4% less than FY24 (previously 74%).
- 495 of the 1,782 facility opened investigations in FY25 were for neglect.
- The number of FY25 neglect opened investigations increased by approximately 14% from FY24.

⁵ There were 476 reportable referred intakes during FY25. Reportable Referred Intakes do not count as opened investigations. Had this number been counted in opened investigations, there would have been a 28% increase in opened facility investigations over FY24.

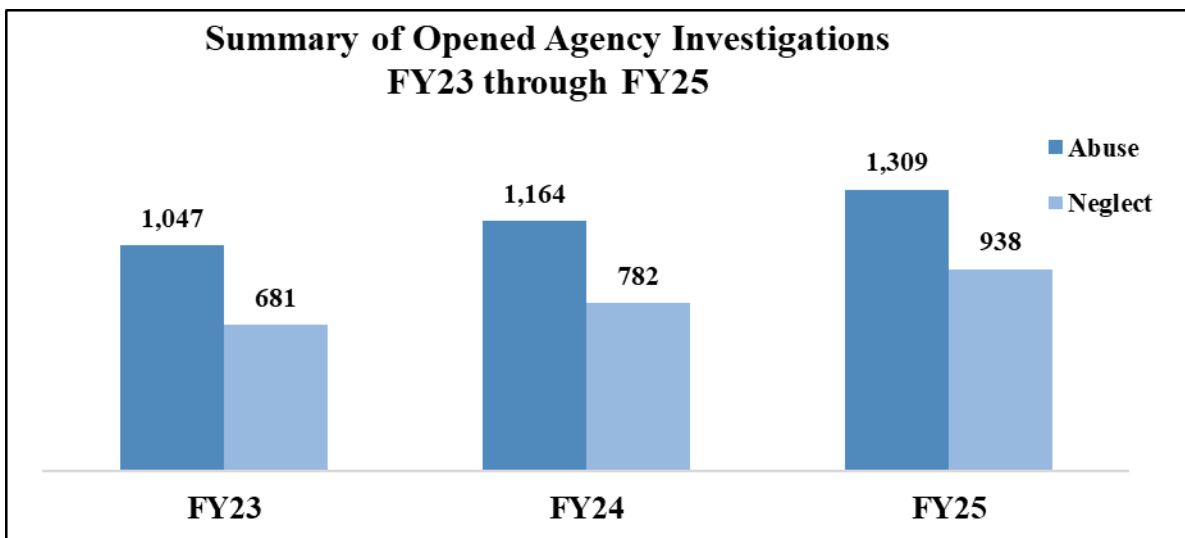


Community Agencies

During FY25, OIG opened 2,247 abuse or neglect investigations pertaining to community agencies, a 15% increase from FY24.

- Of the 2,247 community agency investigations, there were 1,309 opened investigations for abuse, including 94 financial exploitation opened investigations.
- From FY24 to FY25, the total abuse investigations pertaining to community agencies increased 12%.
- Abuse investigations as a percent of community agency investigations received increased 13%, from 60% (FY24) to 73% (FY25).
- OIG opened 938 investigations for neglect pertaining to community agencies in FY25, a 10% increase from the 850 neglect investigations OIG received in FY24.

In FY25, opened investigations pertaining to community agencies accounted for 56% of the total abuse and neglect opened investigations. This number is generally reflective of the fact that significantly more individuals receive mental health and developmental disability 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 FY25, categorized by the type of investigation and program location. In addition to the above-described abuse or neglect investigations that OIG opened during FY25, OIG opened death reviews regarding 250 individuals who either were at the time or had been in the past receiving mental health and or developmental disability services in facility or community agency programs, as compared to 227 death reviews during FY24.

FY25 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	27	12	24	11	21	95	0
Chester	138	69	49	5	81	342	1
Chicago-Read	39	10	31	26	86	192	3
Choate	19	23	6	1	11	60	0
Elgin	42	13	54	9	56	174	1
Madden	18	7	10	0	17	52	1
Packard	19	6	20	2	21	68	0
Facility Totals	302	140	194	54	293	983	6
Community Agencies:							
Residential	13	18	42	10	21	104	7
Non-Residential	13	7	24	11	24	79	12
Agency Totals	26	25	66	21	45	183	19
Total Opened Investigations and Death Reviews	328	165	260	75	338	1166	25

**FY25 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	80	9	20	3	27	139	3
Fox	0	0	0	0	6	6	6
Kiley	79	6	15	3	52	155	3
Ludeman	102	2	14	1	36	155	5
Mabley	29	0	8	0	17	54	6
Murray	88	12	8	2	40	150	16
Shapiro	97	6	11	2	24	140	11
Center Totals	475	35	76	11	202	799	50
Community Agencies:							
Residential	493	47	388	65	780	1773	168
Non-Residential	95	10	66	7	113	291	3
Agency Totals	588	57	454	72	893	2064	171
Total Opened Investigations and Death Reviews	1063	92	530	83	1095	2863	221

Opened Investigations (and Death Reviews) by Bureau

Bureau	Deaths	Financial Exploitation	Mental Abuse	Neglect	Physical Abuse	Sexual Abuse	Grand Total
Central	49	33	163	269	190	37	741
Cook	33	52	158	309	207	41	800
Metro	35	17	120	220	330	17	739

North	56	31	179	325	251	41	883
South	73	25	170	310	413	121	1112
Total	246	158	790	1433	1391	257	4275

Percent Increase in Opened Investigations (and Death Reviews) from FY24 to FY25, by Bureau

Bureau	% Increase in Opened Investigations (and Death Reviews)
Central	-3.6%
Cook	9.9%
Metro	9.0%
North	-1.2%
South	12.3%

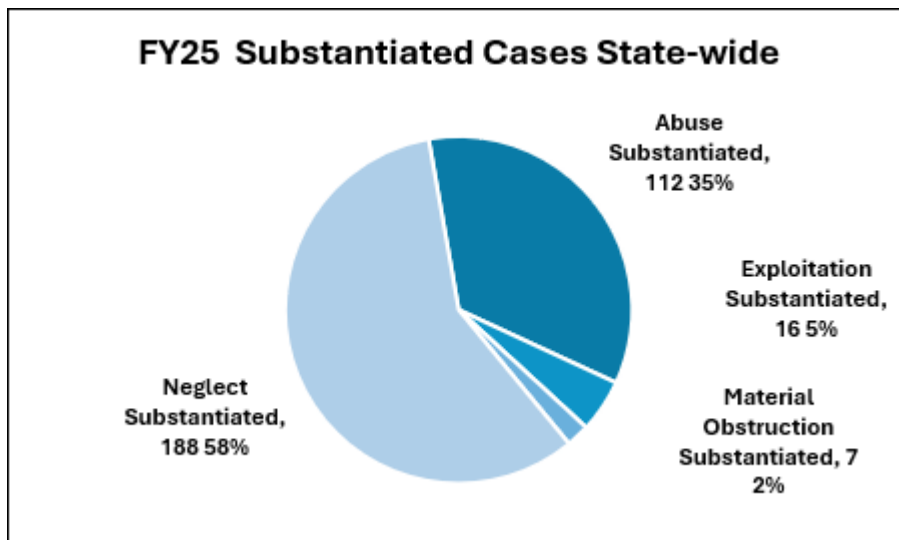
C. Findings

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, neglect, or material obstruction in 323 of the 3,148 investigations it completed in FY25, including 188 substantiated neglect cases, 112 substantiated abuse cases, 16 substantiated financial exploitation cases, as well as 7 substantiated material obstruction of an investigation case. Of the 323 cases where OIG substantiated abuse or neglect, OIG made a total of 400 findings (in some cases OIG will substantiate abuse or neglect against multiple employees or entities), which includes 381 total findings against accused employees and 19 findings against only agencies or facilities.

The below tables reflect: (1) FY25 Substantiated Cases Statewide by Category⁶; (2) FY25 Substantiated Finding Types by Accused Employee; (3) FY25 Substantiated Findings Against Agencies and Facilities; (4) Substantiation Rates for FY23 through FY25; (5) Substantiated Abuse and Neglect Cases by MH Location; and (6) Substantiated Abuse and Neglect Cases by Developmental Location.



FY25 Substantiated Finding Types Against Accused Employees							
	Physical Abuse	Sexual Abuse	Mental Abuse	Financial Exploitation	Neglect	Egregious Neglect	Material Obstruction
Agency Employees							
DD	40	2	51	17	171	2	3
MH	2	0	6	1	2	0	0
Total	42	2	57	18	173	2	3
Facility Employees							
DD	20	2	8	0	35	1	1
MH	2	0	3	0	10	0	2

⁶ Three instances of Substantiated Neglect were found to be egregious.

Total	22	2	11	0	45	1	3
Grand Total	64	4	68	18	218	3	6

FY25 Substantiated Findings Only Against Agencies and Facilities	
Agency Substantiated Findings	
DD – Neglect	14
DD - Material Obstruction	1
Facility Substantiated Findings	
DD - Neglect	3
DD - Material Obstruction	1
Total Agency and Facility Substantiated Findings	19

FY23 through FY25 Substantiated Case Trends

OIG’s overall substantiation rate remained almost the same - in FY25 the substantiation rate was 10.3% and in FY24 it was 11.8%.⁷⁸

Substantiation Rate – FY23 through FY25			
Location	FY23	FY24	FY25
MH State Facility	3.3%	3.7%	2.1%
DD State Facility	7.9%	5.4%	6.8%
MH Community Agency	12.0%	11.3%	5.9%
DD Community Agency	16.7%	18.2%	16.3%
Total	12.1%	11.8%	10.3%

⁷ As OIG works through the backlog of cases, it is very likely that the substantiation rate has dropped as cases that are not likely to be substantiated are cases that can more quickly be documented and closed. Additionally, in an effort to reduce admin leave, OIG has worked to identify cases that will be unsubstantiated or unfounded to reduce the time those employees are out on leave both at facilities and agencies.

⁸ As we near the completion of an entire line of cases, i.e., FY22, FY23, FY24, the substantiation rate of cases reported in the FY and closed at any time will more accurately reflect a true substantiation rate.

FY25 Findings by Mental Health Location

Location	Abuse Substantiated	Financial Exploitation Substantiated	Neglect Substantiated	Material Obstruction	Not Substantiated ⁹	Findings Total
Mental Health Centers						
Alton MHC	1	0	5	1	85	92
Chester MHC	0	0	0	0	225	225
Chicago-Read MHC	0	0	0	0	136	136
Choate MHC	0	0	0	0	22	22
Elgin MH	0	0	1	0	123	124
Madden MHC	2	0	2	0	13	17
Packard MHC	0	0	1	1	56	58
Center Totals	3	0	9	2	660	674
Community Agencies						
Residential	6	1	1	0	38	46
Non-Residential	1	0	0	0	74	75
Agency Totals	7	1	1	0	112	121
Finding Totals	10	1	10	2	772	795

FY25 Findings by Developmental Location

Location	Abuse Substantiated	Financial Exploitation Substantiated	Neglect Substantiated	Material Obstruction	Not ¹⁰ Substantiated	Findings Total
Developmental Centers						
Choate DC	13	0	14	0	210	237
Fox DC	0	0	4	0	6	10

⁹ Of those not substantiated, OIG made recommendations on 30 MH Facility or Community Agency Cases.

¹⁰ Of those not substantiated, OIG made recommendations on 136 DDD Facility or Community Agency Cases.

Kiley DC	1	0	7	0	83	91
Ludeman DC	0	0	2	0	116	118
Mabley DC	0	0	1	0	12	13
Murray DC	7	0	3	1	102	113
Shapiro DC	1	0	1	0	173	175
Center Totals	22	0	32	1	702	757
Community Agencies						
Residential	66	12	124	2	954	1158
Non-Residential	14	3	22	2	146	187
Agency Totals	80	15	146	4	1100	1345
Finding Totals	102	15	178	5	1802	2102

FY25 Substantiated Death Cases

OIG closed 271 death cases (this includes 250 death reviews and 21 full death investigations) during FY25, a significant increase from the 132 death cases OIG closed during FY24. Of the 271 closed death cases, OIG determined that there was no suspicion of abuse or neglect in 188 of the cases. With respect to the 21 death cases where OIG subsequently opened an abuse or neglect investigation, OIG substantiated 8 cases for neglect. As to the other 13 cases that OIG did not substantiate, OIG identified issues that required a written response from the agency or facility in 2 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. By way of background, a 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 and as outlined in an IGA with ISP, OIG suspends 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 2021 through August 2025 (as explained above, that number does not include employees on paid administrative leave who are the subjects of ongoing criminal investigation or prosecution).

SODC Employees on Paid Administrative Leave Due to OIG Investigations¹¹	
July 2021	39
June 2022	46
August 2023	53
June 2024	175
August 2025	181

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.

For the past several Annual Reports, employees on paid leave have been described as being on leave "Due to OIG Investigations." This is understandable because the most risk-averse and prudent action to be taken by SODCs would be to remove employees who are a potential safety risk to individuals until an independent OIG investigation is complete. However, employees only need to be removed from contact with individuals if there is credible evidence that the employee committed abuse/neglect. To be clear, OIG does not place employees on administrative reassignment or leave. OIG only communicates with IDHS that an employee should be removed when it learns that an employee of a facility or agency is working with individuals, and OIG has determined that there is credible evidence determination of abuse or neglect. Otherwise, IDHS is responsible for complying with Rule 50 removal requirements and 405 ILCS 5/3-210 which specifically applies to the state operated facilities. However, with a substantiation rate that has consistently hovered around 10-13%, most allegations investigated by OIG are ultimately determined to be unsubstantiated or unfounded. Credible evidence is certainly a lower threshold of evidence than a preponderance which is necessary for a substantiated finding. Consistently at any given time, there are approximately 400 employees who are on administrative leave and administrative reassignment. This stubbornly high number of employees being barred from working with the developmentally disabled is an untenable strain on overworked staff, an extraordinary cost in overtime to State taxpayers and a risk to already vulnerable individuals.

¹¹ These numbers reflect the number of IDHS Division of Developmental Disabilities employees on paid administrative leave due to OIG Investigations. The SOPHs have only 21 employees on administrative leave.

OIG has worked with IDHS division and facility personnel to identify root causes for the large number of employees on administrative leave and reassignment. There are roughly similar numbers of opened investigations at mental health facilities as at developmental disability centers, with 983 versus 799 respectively. However, the number of employees at any one time on administrative leave/reassignment in mental health facilities is a fraction of those at developmental centers, approximately 20 SOPH employees compared to approximately 400 SODC employees at any given time. The difference is not attributable to the length of investigations between Divisions - as the cases are not handled differently by OIG. In FY26, OIG is working to scrutinize what is the difference between SODCs and SOPHs in how they handle credible evidence reviews and determine whether employees are returned to work appropriately and safely during annual site reviews. In partnership with IDHS, OIG is working with IDPH to determine if the current processes have led IDHS to overuse the administrative leave process in an effort to avoid consequences from IDPH. It is noteworthy that IDPH rules also have a credible evidence threshold for the safety of individuals at State Operated Developmental Centers.

Additionally, OIG is working with IDHS to develop a comprehensive policy on how to safely and consistently conduct credible evidence reviews in an effort to permit accused employees to return to work while preventing future abuse. At the start of the calendar year, State-operated facilities will have the discretion to return employees to work who are accused of allegations that *are not likely to result in a report of the employee's name to IDPH's Health Care Worker Registry* when IDHS determines other protective measures are sufficient to ensure individual safety, such as employee retraining and discipline. OIG will continue to collaborate with IDHS to ensure that staff who are put on administrative leave are placed appropriately and consistently across the State-operated spectrum with the goal of maintaining the safety of individuals. In FY26, OIG is conducting site visits at State-operated facilities to examine each facility's policy concerning credible evidence reviews and the actions taken based upon those reviews.

In the meantime, OIG is working to improve its timeliness rate and eliminate backlogs. As mentioned above, OIG has worked to increase the number of employees authorized to return to work while OIG completes its investigation – all pursuant to 405 ILCS 5/3-210. Notably, in FY25, OIG authorized the return to work of 18 IDHS employees and in the first quarter of FY26, has already surpassed that number. Investigative Bureaus have also prioritized completion of cases that involve an employee on administrative leave.

Lastly, in October 2024, OIG began utilizing its reportable referred process again, 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. After much training on the necessary investigative steps, resolutions of these matters, and the expected communications with OIG, referrals of investigations to facilities or agencies was expanded in the second half of FY25 to further reduce the time employees were on reassignment or leave – thereby allowing OIG to focus on the completion of its own cases.

E. Reconsiderations of OIG Findings

In FY25, OIG received and reviewed 113 requests for reconsideration of OIG’s investigative findings or recommendations, in connection with 107 investigations (an investigation will sometimes result in multiple requests for reconsideration). As background, pursuant to Illinois 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 FY25, OIG received and processed 52 more reconsiderations than in FY24. Of the 113 reconsiderations OIG received in FY25, OIG denied 81.4% and granted 18.6%, as reflected in the below table. Similarly, of the 61 reconsiderations OIG received in FY24, OIG denied 81% and granted 19%.

FY25 Reconsideration Outcomes	# of Cases	Outcomes in %
Denied	86	76.1%
Denied, with the Issuance of an Amended Report	6	5.3%
Granted, with the Issuance of an Amended Report	14	12.4%
Granted, and Reopened Investigation	7	6.2%
Total Reconsiderations	113	

FY24 Reconsideration Outcomes	# 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	

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 (Division of Developmental Disability (DDD) or Division of Behavioral Health and Recovery (DBHR). *See* Department of Human Services Act, 20 ILCS 1305/1-17(n). The affected program Division then reviews and approves the written responses and sends the written response to OIG.

In FY25, OIG received 160 approved written responses from State-operated facilities and 344 from community agencies for a total of 504 written responses, regarding OIG’s findings and recommendations.¹² With respect to the above-described written responses, facilities and agencies detailed the following actions related to OIG’s findings and recommendations:

FY25 Actions Taken			
Personnel Action		Administrative Actions	
Discharged	162	Individual Retraining	175
Written Reprimand	35	Group Training	95
Resignation	47	Policy/Procedural Change	75
Suspension	5	Reviewed	42
Reassigned	26	Treatment Plan Change	9
Counseling	19	Administrative Change	7
Retirement	3	Structural Repair/Upgrade	7
Oral Reprimand	7	No Action	7
Discharged (Other Cause)	14	Supervision	4
		Individual Transferred	8

¹² These numbers include approved written responses OIG received in FY25 regarding cases it completed in FY24.

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 FY25 by location and program division.

FY25 Percentage of Approved Written Responses for which OIG Completed Compliance Reviews (for OIG Opened Investigations)						
	DDD Programs			DBHR Programs		
	Written Responses	Compliance Reviews	%	Written Responses	Compliance Reviews	%
DHS Facilities	97	19	20%	63	14	19%
Community Agencies	319	44	14%	25	5	20%
Totals	416	63	34%	88	19	39%

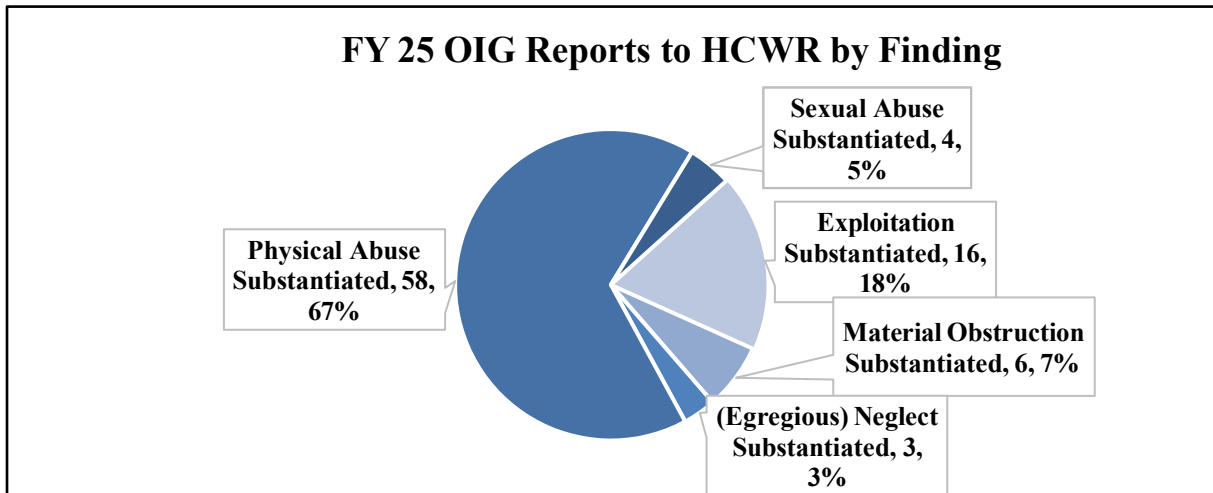
With respect to these compliance reviews, OIG issued 3 “Out of Compliance” letters in FY25 to the same agency for 3 separate cases. The agency subsequently submitted documents, and OIG found 3 cases in compliance.

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, egregious neglect or material obstruction of an investigation, OIG reports the employee’s name to the Illinois Department of Public Health’s Healthcare Worker Registry (HCWR) along with 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 FY25, OIG completed 87 substantiated cases which required initial reports to the HCWR of the employee’s name and the nature of OIG’s finding. During FY25, OIG also made final reports to the HCWR for 57 employees’ names and 65 findings, meaning either the employee did not appeal

the report, or, after a hearing, it was determined that the conduct warranted the reporting.^{13 14} Of the 57 employees, 53 of the reported employees were from DDD and 4 reported employees were from MH. For FY25, OIG's reports to the HCWR placements by finding are reflected in the below chart:



HCWR Administrative Appeal Hearings

If an employee requests an administrative appeal of OIG's HCWR referral, IDHS is required to prove by a preponderance of the evidence that OIG's finding of abuse or neglect "warrants" the reporting of the employee's name to the HCWR. During FY25, 17 employees filed appeals challenging their names and findings being reported to the HCWR. One of the employees withdrew their HCWR petition and their name and finding was placed on the HCWR, 4 petitions were dismissed for failure to appear, and one was dismissed for lack of jurisdiction and thus, those 5 names were placed on the HCWR. One facility case had an administrative resolution prior to arbitration and because a stipulated agreement was required, the employee's name was not placed on the HCWR. Ten of those appeals remain pending at the end of FY25.

The IDHS Bureau of Hearings decided 9 appeals that were filed prior to FY25. The outcomes were as follows.

- 2 employees' appeals were denied, and their names were reported to the HCWR;
- 3 employees' appeals were granted at hearing, and they were not placed on the HCWR;
- 2 appeals were dismissed due to failure to appear for the hearing;
- 1 petitioner withdrew their appeal and was placed on the HCWR; and
- 2 appeals were stipulated and were not reported to the HCWR because the facility employee was successful during a union arbitration; therefore, they could not be reported to the HCWR although the finding remains.
- 3 appeals filed prior to FY25 remained pending at the end of FY25 (2 from FY24 and 1 from FY21).

¹³ The 57 final reports OIG made to the HCWR encompassed cases that it substantiated during FY23 through FY25.

¹⁴ Two employee's names were reported for three separate cases. Three employee names were reported for two separate cases.

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 employee/petitioner to prove by a preponderance of the evidence that removal of their 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 FY25, 9 employees requested hearings to have their names and findings removed from the HCWR. The following is the status of the 9 requests:

- 4 petitions were dismissed because the employee failed to appear for a status hearing, therefore, all 4 employees’ names remain on the HCWR;
- 5 petitions remain pending at the end of FY25.

Two additional HCWR Removal Petitions filed in FY24 were decided during FY25. One employee withdrew their petition and remains on the HCWR. OIG found that the other employee met the criteria for removal, stipulated that the name could be removed, and their name was removed from the HCWR.

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 FY25, there was 1 arbitration that went to full hearing. In that case, OIG substantiated physical abuse against a facility employee who initiated an inappropriate physical hold on and forcibly pushed an individual, causing him to lose his balance and fall to the floor. In the decision, the hearing officer upheld the substantiated physical abuse finding, considered a time period of administrative leave as a “time served” suspension, and returned him to his previous position with no back pay.

The following 5 were resolved prior to arbitration by agreement between CMS and AFSCME.

OIG Finding	Resolution Agreement
OIG substantiated physical abuse against a facility employee when he threw an individual’s coat at the individual, pulled the individual out of a chair, and pushed	The employee was offered the opportunity to resign with no reinstatement rights, had an unpaid leave of absence, and upon resignation, personnel records would be purged. Because

the individual, causing the individual to fall to the floor.	there were no barriers to placement, the employee was placed on the HCWR.
OIG substantiated physical abuse against a facility employee who forcefully grabbed an individual's shirt and slapped the back of the individual's head.	The employee was offered the opportunity to resign with an unpaid leave of absence and was not placed on the HCWR.
OIG substantiated physical abuse against a facility employee who struck an individual in the head with his fist because the individual was biting his arm, while the employee attempted to place the individual in a physical hold.	The employee's discharge was reversed to a 20-day suspension, offered the opportunity to return to work with no back wages and return to their previously certified position. The employee was not placed on the HCW.
OIG substantiated physical abuse against a facility employee who hit an individual on the head three times during a restraint.	The grievance was withdrawn, and the employee was placed on the HCWR.
OIG substantiated physical abuse against a facility employee who pushed an individual in the hallway. The individual was not injured but the inappropriate and non-accidental contact was insulting and provoking, offending a reasonable sense of personal dignity.	The grievance was withdrawn, the employee was offered the opportunity to return to work in non-direct care with no back pay, the discharge was modified to a suspension, and the employee cannot transfer or seek reassignment into any direct care position for a period of three years. The employee was not placed on the HCWR.

Stipulations

OIG instituted a process in FY22 whereby a stipulated disposition can be approved without requiring the accused employee to file an appeal. In FY25, in 1 case, OIG determined that the circumstances surrounding the finding did not warrant reporting to the HCWR and that a stipulated decision not to report the employee's 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.

FY25 Scope

In addition to addressing recommendations from previous fiscal years, the scope of the FY25 site visits were to determine whether facilities provided residents with the required dental care. The site visit dates were as follows:

FY25 Site Visit Dates	
Alton Mental Health Center	July 10, 2024 – November 12, 2024
Chester Mental Health Center	October 29, 2024 – December 31, 2024
Chicago Read Mental Health Center	July 24, 2024 – December 10, 2024
Choate Developmental Center	September 23, 2024 – January 28, 2025
Choate Mental Health Center	September 25, 2024 – January 10, 2025
Elgin Mental Health Center	September 10, 2024 – December 13, 2024
Fox Developmental Center	January 23, 2025 – March 7, 2025
Kiley Developmental Center	March 11, 2025 – April 25, 2025
Ludeman Developmental Center	November 20, 2024 – February 19, 2025
Mabley Developmental Center	March 25, 2025 – May 5, 2025
Madden Mental Health Center	July 22, 2024 – December 5, 2024
Murray Developmental Center	December 11, 2024 – March 6, 2025
Packard Mental Health Center	August 22, 2024 – November 25, 2024
Shapiro Developmental Center	February 25, 2025 – April 17, 2025

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 FY25, OIG made 23 recommendations (15 for mental health facilities and 8 for developmental facilities). OIG found the following during the FY25 site visit process:

- At 8 of the 14 facilities (57%), there were instances where individuals did not receive

timely, consistent and comprehensive dental care;

- At 8 of the 14 facilities (57%), comprehensive dental examination information was not included in treatment or behavior plans;
- At 7 of the 14 facilities (50%), some individuals' refusals to receive dental care were not documented.

OIG made eight repeat recommendations for FY24 recommendations which were not fully implemented during the FY25 site visit.

- At one facility, its Human Rights Committee policy needed updating to include participation of individuals;
- At one facility, its Human Rights Committee did not conduct periodic site reviews as required;
- At one facility, the Human Rights Committee did not meet according to best practice standards;
- At four facilities, Human Rights Committee members were not fully trained and oriented to perform its duties.

Chapter 3: Additional FY25 Data

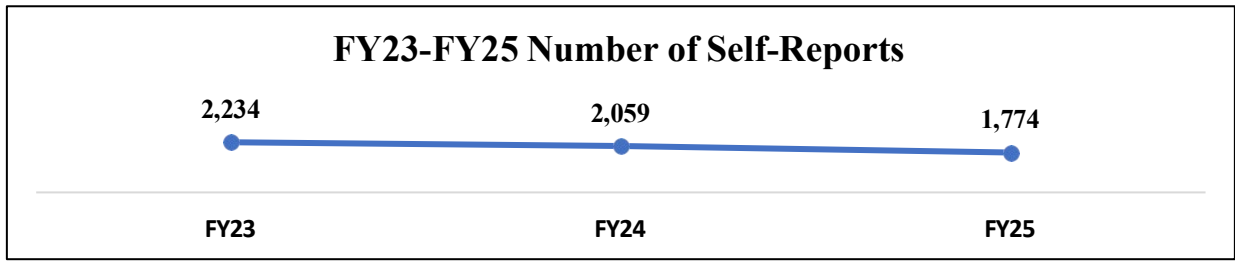
A. Reporting Allegations to OIG in a Timely Manner

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 FY25, OIG received 1,774 *self-reported* allegations of abuse and neglect, a 14% decrease from FY24.



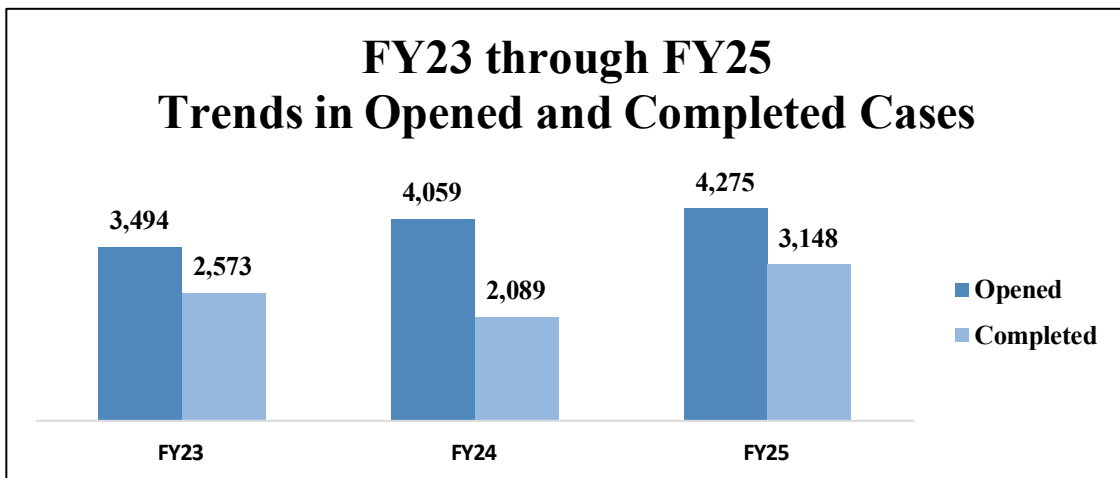
Late-Reporting

The percentage of late self-reports (i.e., reports of abuse, neglect, financial exploitation, and death from facility or community agency employees) decreased slightly from 11.89% in FY24 to 10.48% in FY25. 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.

FY23-FY25 Late Reporting by Program and Disability Type						
FY	Late from Agencies		Late from Facilities		Total Late	Percent Late
	DDD	DMH	DDD	DMH		
FY23	195	27	35	35	292	13.07%
FY24	148	27	39	31	245	11.89%
FY25	128	12	28	18	186	10.48%

B. OIG Caseloads

During FY25, OIG opened 4,275 cases, a 5% increase from FY24.¹⁵ The below tables reflect the number of cases OIG opened and completed from FY23 through FY25.



¹⁵ Since FY22, Bureau caseload figures include complete death reviews.

FY24 and FY25 Investigator Caseload Comparison By Bureau		
	Caseload as of June 30, 2024	Caseload as of June 30, 2025
Central	413	685
Cook	778	1,106
Metro	966	1,389
North	1,317	1,878
South	696	1,057
OIG	4,170	6,115

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. Completion of these sorts of complex cases in a thorough and professional manner 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. During FY25, the average time it took to complete a case increased to 216 from 157 days in FY24. During this time, OIG made a concerted effort to complete older cases in its backlog as reflected below in the 54% increase in completed cases that are over 60 days old and that may have been a contributing factor in the higher average time to completion. As OIG labors under a high level of backlog, cases continue to age. As we work to close those older cases, the average age of a case completion is increasing. Average days to completion do not reflect days

that a case remains in law enforcement status. Recently OIG discovered that many older cases do not accurately reflect the number of days a case may have been in law enforcement status. Although the average time to completion reflects OIG’s efforts to close-out cases that are over 2 years old, the accuracy of the number is difficult to measure due to inconsistent reporting of the closing dates by law enforcement agencies.

Cases Completed Within and Over 60 Days FY23 through FY25		
Fiscal Year	Cases Completed Within 60 Days	Cases Completed Over 60 Days
FY23	37%	63%
	(943)	(1,592)
FY24	25%	75%
	(522)	(1,569)
FY25	23%	76%
	(732)	(2,416)

Cases Completed Within and Over 120 Days FY25		
Fiscal Year	Cases Completed Within 120 Days	Cases Completed Over 120 Days
FY25	43%	56%
	(1,380)	(1,768)

FY25 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
21% (341)	79% (1318)	26% (391)	74% (1098)

FY23 through FY25¹⁶ Average Days for Case Completion		
Fiscal Year	Average Total Days	Average OIG Days
FY23	146.76	141.88

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.

FY24	158.52	157.15
FY25	219	216.93

FY25 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
240	239	195	193

FY25 Average Days for Case Completion by Case Type	
Mental Abuse (Psych)	189
Mental Abuse - Verbal	170
Sexual Abuse	166
Physical Abuse	324
Death Report	185
Neglect	322
Financial Exploitation	207
Neglect - COVID	794
Death Report - COVID	315
Suicide	263

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, 2025, or the last day of FY25.

Below are the census figures and staffing ratios for each type of facility at the close of FY25. 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, 2025, which details the number of individuals in the facility on that day.

IDHS also uses the June 30, 2025, 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, 2025, is reflected in the fourth column of the tables.

IDHS Budget divides the June 30, 2025 direct care staff figures by the June 30, 2025 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, 2025)						
Facility	Direct	Undup. Residents	Average Census	June 30 Census	June 30 Direct Staffing Ratio	Person Days (on books) Annual Total
Alton MHC	169.00	218	125	129	1.31	45,548
Chester MHC	350.40	542	280	280	1.25	102,114
Chicago Read MHC	183.00	367	157	151	1.21	57,178
Choate MH & DC Total	348.70	336	225	216	1.61	82,141
Elgin MHC	413.10	991	419	419	0.99	153,116
Fox DC	192.00	74	68	67	2.87	24,742
Kiley DC	440.30	182	166	169	2.61	60,637
Ludeman DC	782.00	329	313	296	2.64	114,269
Mabley DC	210.40	114	105	101	2.08	38,163
Madden MHC	94.10	1,702	85	78	1.21	30,909
Murray DC	474.10	313	275	285	1.66	100,429
Packard MHC	119.80	317	146	150	0.80	53,422
Shapiro DC	895.60	494	468	462	1.94	170,771
Total DD	3,343.10	1,842	1,620	1,596	2.09	591,152
Total MH	1,329.40	4,137	1,212	1,207	1.10	442,287

Total DD and MH Facilities	4,672.50	5,979	2,832	2,803	1.67	1,033,439
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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 FY25 were:

- Saul Morse, Chairperson
- 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 FY25, all by teleconference. The meeting dates were as follows:

- June 18, 2024
- August 20, 2024
- October 15, 2024
- December 17, 2024
- February 18, 2025
- April 15, 2025
- June 17, 2025

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.

FY 25 Mortality Review Board Members were as follows:

Continuing Members from FY24

- Dr. Dennis Beedle, MD, Chair
- Dr. Catherine Counard, MD MPH, Member
- Anne Fitz, APN, Member
- Dr. Scott Gershan, MD, Member
- Chris Helfrich, RN CDDN, Member
- Randy Malan, BSP, Member
- Stacey Aschemann, JD, Member
- Dr. Mary Keen, MD, Member
- Dr. Donnell Barnett, PhD, Member

New Members during FY25

- Casandra Watson, RN, MSN, Member
- John Erzen, MD, Member
- Austin Curtis, MD, Member

Board Resignations

- Dr. Rueben Heyman-Kantor, MD
- Dr. Nicole Lentini, MD
- Ryan Thomas
- Dr. Joyce Miller, MD

The MRB held 4 meetings in FY25, all by teleconference, as follows:

- July 17, 2024
- October 16, 2024
- January 15, 2025
- April 16, 2025

Chapter 4: Areas of Advancement

During FY25, OIG, DDD, and IDHS made the following statutory and or policy changes, which impact OIG’s work.

A. Cameras at DDD 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 options for the installation of internal security cameras at the facility.

To date, the policy for camera use has been finalized at each DDD facility. The following is the status of camera installation at DDD facilities:

Security Camera Installation Status¹⁷		
	FY24	FY25
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.	296 inside cameras and 39 outside cameras are live. Two new outside cameras and 1 inside camera were installed, but they are not in test mode yet.
Fox DC	84 cameras are wired and 78 are installed. The Fox DC camera project is not in test mode yet.	84 cameras are installed and are in test mode.
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.	424 cameras are installed. 6 left to install. Cameras are 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.	Total cameras will be 437. 324 camera lines have been wired. Cameras are not in test mode yet.

¹⁷ Per DDD, “in test mode” means live video but not recording.

Mabley DC	Wiring completed. 78 cameras received. Cameras are being installed. The Mabley DC camera project is not in test mode yet.	78 cameras installed and are in test mode.
Murray DC	Wiring in process. There will be 187 cameras. The Murray DC camera project is not in test mode yet.	187 cameras are live.
Shapiro DC	Wiring in process. There will be 677 cameras. The Shapiro DC camera project is not in test mode yet.	There will be 687 cameras installed. The cameras are not in test mode yet.

Adding cameras to DDD facilities already has impacted OIG’s work. During FY25, OIG substantiated 12 cases with video camera evidence from the newly installed cameras.

B. Reportable Referred Intakes

During FY21, in order to ensure that OIG was using its limited investigatory resources in the most efficient and effective manner possible, OIG initiated a pilot project—which it developed in conjunction with DDD, DBHR and several advocacy organizations—wherein OIG’s Intake Bureau, with Inspector General approval, referred cases to the State-operated facilities to address situations where: (1) the allegation, if true, would likely not result in a report to the Health Care Worker Registry; (2) another entity was better positioned to immediately address the situation; and/or (3) the reporting entity or person had already identified the primary facts relevant to the allegation, meaning additional investigative work would be of minimal value. OIG did not refer allegations if they: (i) presented an emergency situation; (ii) indicated that an individual was in imminent danger; or (iii) would likely result in the reporting of an employee to the Health Care Worker Registry. On April 4, 2023, amendments to Rule 50 codified the Intake Pilot Project OIG implemented during FY21 and authorized reportable referred intakes for agencies and facilities.

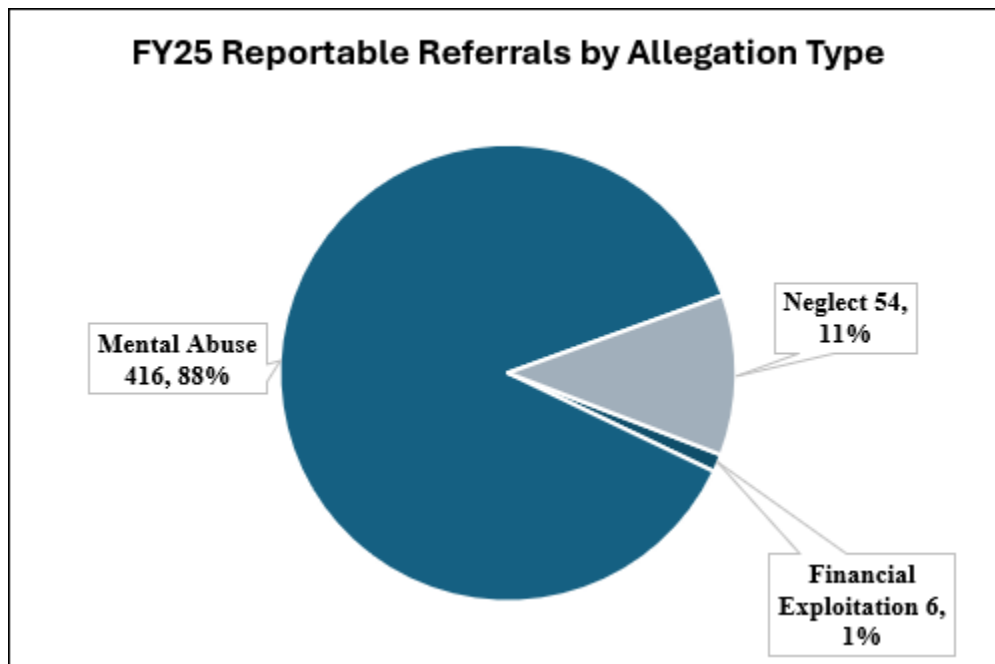
A Reportable Referred intake is an OIG notification that fits all of the jurisdictional requirements of an allegation of mental abuse, simple (non-egregious) neglect or *deminimus* financial exploitation that may be referred to the facility or agency. The facility or agency must complete an investigation of the matter and respond to OIG within 45 days explaining what happened during the incident and any action taken on the matter. If additional information is learned that would warrant a full OIG investigation, the facility or agency must report that information to OIG for a determination of whether a full investigation will be opened. All reportable referred response forms are reviewed by investigative and compliance staff. A sampling of those cases is reviewed by OIG’s compliance team which involves the requesting of all facility investigative material that was the basis for the reportable referred response.

In FY25, OIG worked to train facility staff on investigative requirements, reportable referred response forms, and necessary logistics to implement this Rule 50 change. Initially, OIG began referring mental abuse cases to facilities for investigation and administrative action. Near the end of the FY25, reportable referred intakes were expanded to minor neglect and *deminimus* financial exploitation cases. In FY25, 476 cases were referred, most of which were in the last quarter and nearly all of which were in the last half of the fiscal year.

FY25 saw an increase of only 1.6% of reportable intakes to OIG from facilities. If reportable referred intakes were accounted for, there would have been an increase of 29% of reportable intakes at facilities. Going forward, the impact of reportable referred intakes will allow OIG to focus the bulk of its investigative resources on its most serious allegations. Additionally, as seen above mental abuse cases make up a large number of the substantiated cases. The substantiated case rate may be impacted by removing these reportable referred intakes.

OIG reviews all response forms for appropriate dispositions before closing those reportable referred intakes. Our Bureau of Compliance and Evaluation perform a compliance review similar to the way it handles written response forms for a sampling of reportable referred intakes.

Below are the number of cases referred to each Division during FY25.



FY 25 – Number of Reportable Referrals Per Division	
DD	100
MH	376
Total # of Cases.	476

The following table shows the total number of outcomes as a result of the referrals.

FY 25 – Reportable Referral Outcomes¹⁸	
Administrative Discipline Imposed	5
No Action Taken	308
Non-Disciplinary Action - Other	11
Non-Disciplinary Action - Retraining	29

C. Reduction of Backlog

In FY 25, the Auditor General made multiple findings against OIG regarding the timeliness of its investigations. Specifically, the Auditor General stated “[OIG] should work to improve the timeliness of investigative case completion by identifying the barriers that are preventing timely completion and seeking the appropriate remedies for the issues identified.” After those findings, OIG undertook several initiatives to more efficiently complete investigations. OIG streamlined the writing of reports for unsubstantiated and unfounded cases by prioritizing the analysis of evidence rather than the exhaustive recitation of investigative steps taken in a particular case. Furthermore, in cases older than one year that were supported by an internal investigation by OIG trained personnel at facilities and agencies, it permitted investigators to review those materials and make findings based on that internal investigation in non-HCWR registry cases. OIG also continued to authorize virtual and phone interviews to reduce the time that investigators spent traveling. The initial results show an increase of approximately 14 cases per investigator in the months preceding these initiatives to approximately 19 cases submitted per investigator in the months after the measures were taken at the end of FY25. OIG continued these efforts into FY26 and is working to ensure there is no reduction in the strength or consistency of OIG’s findings.

D. New OIG Training Staff

During FY24, OIG hired two training staff, and the Bureau of Policy and Legislation became the Bureau of Policy and Training. The focus of the training bureau is to provide high-quality training to new and existing investigators, as well as to provide Rule 50.30(f) trainings to facility and community agency staff. Highlights of the work done during the last 7 months of FY25 include the following:

- Trained the new hire training staff on OIG practices;
- Developed and implemented a new hire training tracking process for OIG staff;
- Updated/developed 10 OIG trainings;
- Trained OIG new hires;

¹⁸ There are 145 reports that are waiting responses. Facilities have a grace period to respond.

- Developed a monthly employee newsletter, to inform staff of upcoming trainings and to provide policy tips;
- Provided facility and community trainings;
- Developed a community agency newsletter;
- Developed an OIG Training Template; and
- Developed an OIG Training Banner for community events.

E. Public Act 104-0270 – Sharing OIG Information

On August 15, 2025, Public Act 104-0270 was signed into law. The following two changes were made to OIG’s enabling statute.

In the Spring of 2025, OIG submitted a legislative proposal seeking to amend 20 ILCS1305/1-17 to 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. This legislation also allows OIG to share unsubstantiated and unfounded Investigative Reports (and corresponding casefile) when OIG determines there is credible evidence of neglect for someone not within OIG’s jurisdiction.

In the Spring of 2025, OIG submitted a legislative proposal seeking to amend 20 ILCS1305/1-17 to allow OIG to share Death Reports with recommendations with the IDHS Secretary or their designee, as well as the relevant agency or facility. By statute, the following deaths are called into the OIG Hotline when there is no allegation of abuse or neglect:

- (1) any death occurring within 14 calendar days after discharge or transfer from a residential program or facility;
- (2) any death occurring within 24 hours after deflection from a residential program or facility; and,
- (3) any death occurring at an agency or facility or at a Department-funded site.

An OIG Medical Analyst will review the case to determine if there is credible evidence of abuse or neglect surrounding the death. If so, the case is opened for full investigation. If not, a Death Report is prepared, and the case is closed. The Medical Analyst has authority to issue a recommendation(s) in the Death Report if there is an issue that does not rise to a finding, but the facility or community agency needs to address to prevent future abuse and neglect. Prior to this legislation, the facility or community agency would receive the recommendation language, but not the Death Report, so the facility or community agency may not have the full context why the recommendation was made. With these amendments, the facility or community agency will now receive the full Death Report. The effective date of this legislation is January 1, 2026.

F. Public Act 104-0327 – Accused Employees and Administrative Leave

On August 15, 2025, Public Act 104-0327 was signed into law. In the Spring of 2025, DHS submitted a legislative proposal seeking to amend the Mental Health and Developmental Disabilities Code, 405 ILCS 5/3-210, to give the Department some discretion in determining when

to place an accused employee working at a State-operated developmental disabilities facility on administrative leave when there is an allegation of mental abuse, neglect, or financial exploitation under \$20. Prior to this legislation, the statute required an automatic immediate bar of an accused employee from contact with all individuals for all OIG finding types, regardless of the severity of the allegation. Public Act 104-0327 allows DHS to provide a targeted and reasoned response considering the severity of the allegation when there is an allegation of mental abuse, neglect, or financial exploitation under \$20, which may include, but is not limited to administrative leave, administrative reassignment, training, or discipline. The automatic and immediate bar from patient contact remains when there is an allegation of physical abuse, sexual abuse, financial exploitation of \$20 or over, egregious neglect, and material obstruction of an investigation. The effective date of this legislation is January 1, 2026.

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
- Interviewing
- Report Writing
- Appeals Rights and Testifying
- OIG Database
- Role of Medical Analysts
- Person Centered Planning

More senior and experienced ISI-2's, under close supervision of their Bureau Chief and Investigative Team Leader, also participate in mentoring newly hired ISI-2's. OIG conducts regular assessments to ensure the new probationary ISI-2's 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.

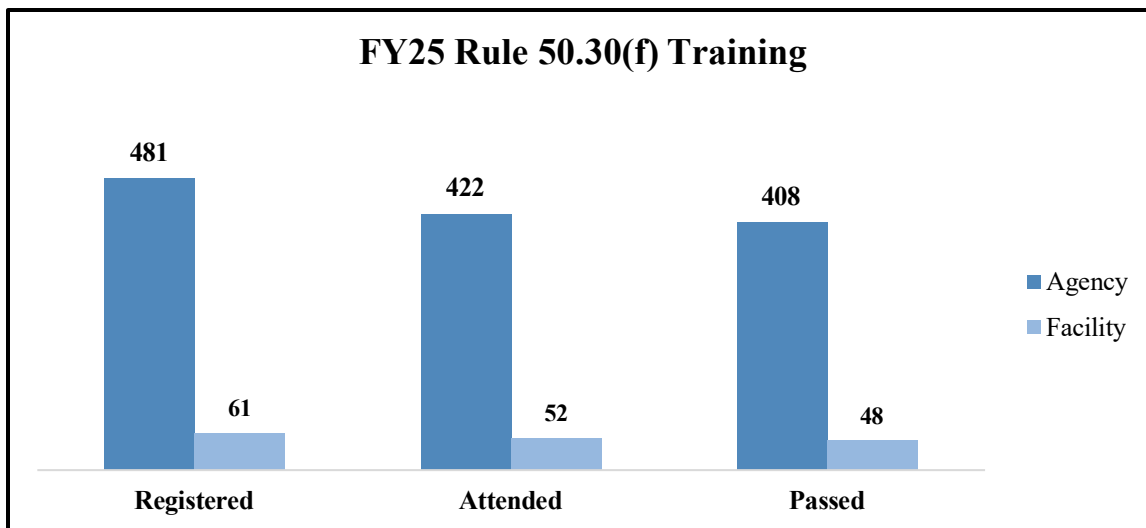
In FY25, OIG staff completed all necessary courses to meet these requirements, OIG used IDHS' OneNet system to initiate, implement and document OIG staff trainings.

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 FY25, 542 agency and facility staff registered for OIG's online 50.30(f) training, 474 attended the training and of those, 456 passed. To pass the training, the staff are required to score 70% or better on a test. Roughly 97% of agency staff and 92% of facility staff who took the training passed the test. The numbers of agency and facility staff that registered, attended, and passed the training are reflected in the table below.



OIG Investigative Steps

OIG also provides an online "Investigative Steps" training for employees at IDHS' Developmental and Mental Health Centers that provides instruction on interviewing and document/evidence collection. For a Facility employee to become a Facility Investigator (which allows them to play a more significant role in the initial response to an allegation, including conducting interviews instead of gathering statements), they must take the Investigative Steps training. During FY25, 36 facility staff registered for the training, 34 facility staff attended. This training has no 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 FY25, 551 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 323 cases OIG substantiated in FY25.

5824-0070 - OIG established a finding of material obstruction of an investigation where its investigation found that a facility employee intentionally made an anonymous false allegation of physical abuse regarding another employee, resulting in OIG expending limited investigative resources on a false allegation that resulted in an unfounded finding. The facility employee also lied during their interview with OIG to cover up their actions when they denied making the false allegation to the OIG Hotline. An RPA decision gave the employee the opportunity to resign from their position. The accused employee did not request a 50.90 appeal. 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.

2920-0095 - OIG established three findings of physical abuse where its investigation established three facility employees struck an individual in response to their behavior, and one of the employee's choked the individual. This resulted in extensive bruising to the individual's head, face, neck, back, chest, and right hand including a shoe print bruise that matched one of the employee's shoes. OIG also established a finding of neglect against a fourth employee as they failed to intervene on the individual's behalf during the assault, which resulted in additional pain and injury to the individual. OIG recommended that the facility ensure that its staff were properly trained regarding standard operating procedures for restraint use as facility protocol was not followed.

One employee pled guilty to Battery, a Class A Misdemeanor, and was sentenced to 11 days in jail with credit for 11 days' time served, 18 months' probation, and a fine. The second employee pled guilty to Battery, a Class A Misdemeanor, and was sentenced to one day in jail with credit for one day served, 24 months' probation, anger management counseling, and a fine. The third employee pled guilty to Failure to Report Abuse or Neglect in a Residential Facility, a Class A Misdemeanor. The employee was sentenced to 10 days in jail with credit for 10 days served, 20 months' probation, 20 hours community service, and a fine. A fourth employee pled guilty to Battery, a Class A Misdemeanor, and was sentenced to three days in jail, with credit for three days served, 18 months' probation, 30 hours of community service, mental health evaluation and treatment to include anger management counseling, and a fine.

The facility's response to the investigation was one employee was terminated from his position, two employees were no longer employed from the facility, and one was discharged. OIG subsequently reported three of the employee's names and OIG's finding to the HCWR, rendering those employees ineligible to be employed by an Illinois health care employer. The facility also stated that employees are trained annually on restraint policy. The facility would continue with annual trainings and provide refresher training when deemed necessary.

2921-0056 - OIG established a finding of physical abuse where its investigation established a facility employee choked an individual with a towel while the individual was in restraints. The individual lost consciousness soon after and required emergency medical attention. As a result of the incident, the individual had marks on their neck which were consistent with being choked. The local prosecutor declined to prosecute. The facility's response indicates the employee is no longer employed at the facility. The accused employee did not file a 50.90 appeal. 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.

2920-0066 - OIG established a finding of physical abuse where its investigation established a facility employee hit an individual multiple times with a belt. The employee pleaded guilty to Aggravated Battery and, in the plea hearing, admitted to hitting the individual multiple times with a belt. OIG recommended the facility take action against two other employees for obstructing OIG's investigation. The facility's response to the investigation was that the three employees were discharged. The accused employee did not file a 50.90 appeal. 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.

2924-0168 - OIG established a finding of physical abuse where its investigation established a facility employee slammed an Individual to the floor and put their knee on the Individual's face with excessive force, as observed on video. The Individual sustained a cut to their left cheek, right lip, and lower left lip. The employee pleaded guilty to Battery, Class A Misdemeanor, and received 24 months' probation, a fine, and was ordered to participate in an anger management class. The employee did not file a 50.90 appeal. 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.

1324-0111 - OIG established a finding of physical abuse where its investigation established a community agency employee physically abused three individuals. Video evidence showed the employee striking, pushing, shaking, and grabbing two individuals, and pushing the third individual's hand aggressively. One individual was found with unexplained injuries, bruising around their eye, on their shoulder, on their back, and a red swollen spot on the top of their head. The employee pled guilty to Criminal Abuse of a Person with a Disability, a Class 3 felony. OIG found aggravating circumstances in that the employee subjected the individual to physical abuse that were painful and continuous over the course of two days. The community agency's response to the investigation was that the employee was terminated. 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.

1325-0059 - OIG established a finding of physical abuse, mental abuse, and neglect where its investigation established a community agency employee failed to adhere to an Individual's plan to de-escalate behaviors and yelled and called the Individual a "little b_ch." The employee then threatened physical violence against the Individual by their boyfriend. As a result, the Individual's

behaviors escalated. When the Individual became physically aggressive towards the employee, the employee grabbed the Individual's wrists and pushed the Individual. The community agency's response to the investigation was that the employee was terminated. 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.

2924-0237 - OIG established a finding of neglect where its investigation established a facility employee used inappropriate techniques when an individual became physically aggressive. The employee grabbed the Individual around the neck and pushed the individual against a wall and grabbed the Individual around the body, causing the Individual to fall to the floor. The Individual ultimately required being placed in mechanical restraints. OIG did identify mitigating circumstances because the employee was working alone with a large group of Individuals at the time of the incident, and the employee was attempting to protect herself when she used the inappropriate techniques. The facility's response to the investigation was the employee was discharged and is appealing the discharge.

2924-0277 - OIG established a finding of physical abuse where its investigation established, with the aid of a video recording, that a facility employee used both hands to grab an Individual's hands and pushed the Individual approximately four feet into a wall. The employee quickly threw the individual to the floor as they resisted. The employee got on top of the Individual with their knee on the Individual's lower torso. A short time later, the employee walked closely behind the Individual while using both of their hands to hold the Individual's hoodie, from the back. The employee then swung the Individual around with excessive force into a wall, and then swung the Individual in the opposite direction. Finally, the employee threw the Individual to the ground with excessive force, causing the Individual's body to spin in the air before landing on the floor. The employee used their left knee and placed it on the Individual's neck as the Individual squirmed around on the floor, while pushing upwards to get the employee off them. The facility's response to the investigation was the employee separated from his position. 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.

2924-0150 - OIG established a finding of physical abuse where its investigation established that a facility employee slapped an Individual in the face, while the Individual was being physically held on the floor. OIG recommended that facility staff undergo routine de-escalation training, particularly when dealing with aggressive individuals. OIG further recommended that the facility impress upon its staff to immediately report instances of abuse and neglect. In the instant case, video surveillance showed two employees observed the slap; however, neither reported the incident to OIG, as is required. The facility'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. The facility also stated that staff are annually trained and retrained when deemed necessary on de-escalation techniques and Rule 50.

2924-0287 - OIG established a finding of physical abuse and mental abuse where its investigation established that a facility trainee employee slapped an Individual's hand/face as a reflex to the Individual grabbing the trainee's glasses. The trainee also hit the Individual in the head with a piece of paper and grabbed the Individual's wrist. Additionally, the trainee taunted the Individual by yelling within one inch from their face and used an aggressive posture which exacerbated the Individual's behavior. OIG recommended that the facility review a second employee's reaction to the incident as they did not see the first employee's actions as abuse, which gives rise to the

concern that the first employee's actions may have been common practice or that the second employee did not know how to identify abuse. The facility's response was that the accused employee resigned. The facility also stated the second employee was retrained on Rule 50. The accused employee did not file a 50.90. 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.

1324-0253 - OIG established a finding of neglect where its investigation established that a community agency employee failed to conduct required routine 30-minute bed checks on an Individual from 11:00 p.m. through 3:30 a.m. During this time, the Individual collapsed in the laundry room. At 3:30 a.m., the employee found the Individual in the laundry room and failed to immediately call 911, as directed. The employee claimed the Individual was alive when they found the Individual, but it was determined that the Individual was deceased for at least two hours. Although the investigation was not able to determine the employee's failure directly resulted in the Individual's death given their medical condition, the employee's failure to conduct regular checks on the Individual made it less likely that the Individual could receive timely medical attention that might have saved their life. The community agency's response to the investigation was the employee was terminated.

1323-0163 - OIG established a finding of financial exploitation where its investigation established that a community agency employee opened credit cards in the name of two Individuals, without their consent or knowledge. The employee made multiple purchases on the credit cards for their personal gain. The employee pled guilty to Aggravated Identity Theft, a Class 3 felony, and was sentenced to probation and ordered to make restitution to one Individual in the amount of \$1,619.91 and to a second Individual in the amount of \$658.48. The community agency's response to the investigation was that the employee was terminated. 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.

1323-0211 - OIG established a finding of financial exploitation where its investigation established that a community agency employee financially exploited two individuals in a combined amount of over \$8,000. The employee cashed numerous checks belonging to the individuals, signing their name as the endorser. The individuals did not receive the money and the employee used some of the funds to purchase a water slide for a friend. The employee ultimately pled guilty to theft and was ordered to pay restitution. The community agency's response to the investigation was that that the employee resigned their position and their resignation was accepted. 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.

1324-0057 - OIG established a finding of neglect where its investigation established that a community agency failed to provide 1:1 supervision as required due to their known issues of pica and elopement. The Individual eloped, entered a neighboring garage, and consumed a large quantity of soda and energy drinks resulting in vomiting and an injury to their gastrointestinal tract, requiring hospitalization, and advanced care procedures. OIG identified aggravating factors that the agency was fully aware of their elopement behavior and pica, including multiple prior substantiated OIG cases, and still did not ensure adequate staff for their safety. The community agency's response to the investigation is the Individual is no longer with the agency.

1824-0004 - Although OIG was not able to establish a finding of neglect against two facility administrators for an allegation that they were screening allegations of abuse and neglect and

failing to report abuse and neglect allegations, OIG found the facility had been operating under a policy that did not clearly delineate the allegations or incidents that should be reported to OIG. OIG made the following recommendations to the facility: (1) ensure its policies and training are consistent with Rule 50 so staff know they can report allegations directly to the OIG hotline in place of the internal structure where staff members are required to or think they are required to report allegations only up their chain of command, as this could chill reporting; (2) review and update its reporting policies to ensure there is a thorough review of incidents to ensure there is not a reportable allegation and to ensure the health and safety of the individuals; (3) review its practice of destroying documentation after 6 months as it does not appear to be consistent with State and DHS retention requirements; (4) ensure guardians are notified whenever an allegation of abuse or neglect is made and when OIG has initiated an investigation, which is required by Rule 50. OIG has not received the facility's response to this investigation.

4522-0082 - OIG established a finding of neglect where its investigation established that a facility employee who was assigned to maintain 1:1 supervision of an Individual failed to record required contemporaneous observations of the Individual, and that these failures contributed to the individual's death caused by choking on "food bolus." OIG also established a finding of neglect against a second facility employee for failure to ensure the home was staffed sufficiently to meet the Individual's needs. OIG recommended that the facility address the supervisor's failure to ensure the Individual's 1:1 observation record was completed per facility policy, being every 15 minutes. OIG also recommended that the facility retrain two employees as they failed to immediately administer emergency care to the Individual. The facility's response to the investigation was that the two employees with the neglect findings have been discharged and the time to appeal has not closed.

1924-0051 - OIG established a finding of material obstruction of an investigation where its investigation established that during an investigation into an allegation that a facility employee sexually abused an Individual, the facility employee provided false information to the facility as it initiated the preliminary steps of the OIG investigation, as provided by Rule 50.30(f), and the employee refused to cooperate with OIG's attempts to interview them after they gave a conflicting account of events during a union rebuttal to discipline. OIG's investigation did not establish a preponderance of evidence that the employee had sexual contact or intimate physical contact with the Individual. The facility's response to the investigation was that the employee was discharged. Pursuant to an administrative resolution prior to arbitration, the employee was returned to work and the employee's name will not be placed on the HCWR.

1124-0108 - OIG established a finding of physical abuse and mental abuse where its investigation established that a community agency employee struck an Individual on the back of their head and lower body with a battery pack, resulting in a hematoma to the Individual's head. The employee also grabbed the individual by their shirt, dragged them across the floor, and forcefully pushed them into a corner. The employee also used the battery pack to intimidate and confine the Individual to a corner. OIG also found the employee mentally abused a second Individual who became fearful and started screaming when they witnessed the abuse to the first Individual. OIG recommended that the agency address the failure of an employee to report the allegation to OIG in a timely manner. The community agency's response to the investigation was that the accused employee was terminated due to the allegation. The temporary staff that failed to report the allegation in a timely manner is no longer used by the agency for an unrelated reason. A 50.90 hearing is scheduled.

1124-0157 - OIG established a finding of neglect where its investigation established that a community agency employee secluded an Individual in a bathroom for several hours. The Individual was not independent and needed support to identify hazards or to evacuate. The community agency's response to the investigation was that the employee was no longer employed at the agency due to the allegation of neglect.

1124-0195 - OIG established a finding of neglect where its investigation established that a community agency employee left two Individuals unattended and unsupervised in their home during the evening for at least one hour, while they slept. The employee left the garage overhead door open and the interior garage door unsecured. The employee was observed at Walmart and a gas station. The community agency's response to the investigation was the employee was terminated due to the allegation of neglect.

1124-0338 - OIG established a finding of sexual abuse where its investigation established that a community agency employee took a photograph of an Individual and shared the image in a group chat on Instagram. The photograph showed a sexually explicit image of the Individual. The matter was referred to local law enforcement. The community agency's response to the investigation was that the employee was terminated for reasons related to the allegation. A 50.90 hearing was held, but a decision has not been rendered.

Chapter 7: Closing Remarks

A. IDHS OIG Chief Administrative Officer Jesse Escarpita

FY25 was another very busy year for OIG's administrative operations. OIG's headcount increased from 89 to 114 in FY25 and we oversaw the hiring of nearly 50 positions. Among the new hires were crucial supervisory positions such as a new Deputy Inspector General, Northern Office Administrator IV, Data Manager, Bureau Chief, and multiple Investigative Team Leaders. OIG was also able to fill strategic hires that were created in FY24. These strategic new hires included two Investigative Trainers, a Contracts Specialist, and a Senior Compliance Analyst for program reviews. These new positions will contribute to OIG operations by uniformly training investigative staff and community agencies, assisting on OIG contracts and invoicing related work, and performing targeted program reviews at SOPH and SODC facilities and community agencies.

In FY25, OIG received legal authority to conduct discretionary, in-depth program reviews targeted at addressing the root causes of abuse and neglect at SOPH and SODC facilities and community agencies across the State.¹⁹ These reviews aim to strengthen and improve services for individuals with mental illness and developmental disabilities by providing targeted analysis and actionable recommendations at a specific facility or community agency. OIG spent the latter part of FY25 implementing a program review framework, training the new Senior Compliance Analyst, and developing review topics. OIG expects to conduct its first program review in FY26.

OIG successfully completed its FY25 site visit on dental care. The objective of the site visit was to determine if SOPH and SODC facilities could provide reasonable assurance that individuals were receiving the required dental care as outlined in the State of Illinois Administrative Code Title 59. OIG found that some individuals were not receiving required dental care within the required timeframe. OIG also found that some facilities could not prove they followed up on

¹⁹ See Public At 103-0752.

referrals for individuals. In other instances, facilities could not prove that dental work for individuals was completed following the recommendations of a dentist.

OIG is optimistic about its administrative operations in FY26. In FY25, OIG procured an online legal investigative research application called CLEAR. This application has proven to benefit our investigative operations such so that OIG plans to renew CLEAR for FY26. OIG expects to fill two investigative senior leadership positions. When filled, OIG's senior leadership team will be fully staffed for the first time in over two and a half years. OIG will also explore procuring a customer service and workflow software to help enhance its Intake and Hotline operations. Finally, as previously stated, OIG will also be conducting its first program review in FY26. With these new resources, OIG expects FY26 to be a busy and impactful year for its operations.

B. Acting Inspector General C. Thor Martin

In FY26, OIG has two organizational priorities at the foundation of our mission to protect individuals by thoroughly investigating abuse and neglect - Timeliness and Consistency. Through training and collaboration within our own organization, we seek to bring uniformity to our investigations, reports, and findings. Timeliness of OIG investigations is essential to addressing the needs of individuals and the overall care within an ecosystem of agencies, facilities and Department leadership. Delayed cases suppress the voices of individuals and their loved ones, increase staffing shortages, frustrate employees and care giving organizations, and risk the loss of credible evidence of abuse and neglect.

OIG is hopeful that its increased staffing, improved training, growing experience, efforts to reduce the length of time that personnel vacancies are open, along with increased efficiencies and higher standards of expected performance, will dramatically improve case closures, timeliness of investigations and most importantly the safety of persons receiving mental health and developmental disabilities services throughout this great State.

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.