

Department of Health and Human Services
Office of Inspector General



Office of Audit Services

July 2025 | A-04-24-02504

North Carolina Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Infection Control



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Why OIG Did This Audit

- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that participate in Medicaid are required by CMS to comply with requirements intended to protect residents. This includes requirements related to life safety and emergency preparedness plans. Facilities are also required to develop infection control programs.
- In North Carolina, the State's Department of Health and Human Services (State agency) conducts surveys of ICF/IIDs for compliance with federal requirements.
- This audit is part of a series of audits that assesses compliance with CMS's life safety, emergency preparedness, and infection control requirements for ICF/IIDs.

What OIG Found

We identified 14 deficiencies related to life safety and infection control at the 3 ICF/IIDs operated by North Carolina. We did not identify any deficiencies related to emergency preparedness.



These deficiencies put the health and safety of residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency.

What OIG Recommends

We recommend that North Carolina:

1. verify that the three ICF/IIDs we inspected have taken corrective actions on the life safety and infection control deficiencies identified during the audit,
2. work with the applicable ICF/IID to determine whether mold exists, and
3. work with CMS to develop standardized life safety training for staff at ICF/IIDs.

The State agency concurred with two of our recommendations and detailed steps it has taken in response to our recommendations. For our third recommendation, the State agency did not indicate concurrence or nonconcurrence.

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INTRODUCTION

WHY WE DID THIS AUDIT

Previous Office of Inspector General (OIG) audits on life safety, emergency preparedness, and infection control at nursing homes have identified multiple issues that put people who reside in the homes, such as the elderly, at risk. These issues included life safety violations such as blocked exits and out of date fire extinguishers, emergency preparedness plans that were not updated, and infection control violations such as missing medical record documentation for immunizations.

As part of our oversight activities, OIG is expanding this type of work to include intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs). In addition to intellectual disabilities, many people who reside in ICF/IIDs have limited or no mobility, seizure disorders, behavioral problems, mental illness, or visual or hearing impairments. People with these disabilities are particularly vulnerable to fire or other emergencies. ICF/IIDs are also communal living environments; therefore, residents are susceptible to infectious diseases. This audit, which focuses on ICF/IIDs in North Carolina, is part of a series of audits that assesses compliance with the Centers for Medicare & Medicaid Service (CMS) requirements for ICF/IIDs related to life safety, emergency preparedness, and infection control. The first audit in this series found deficiencies related to life safety and emergency preparedness in Massachusetts that were similar to those found in nursing homes.¹ Appendix B contains a list of completed related audits.

OBJECTIVE

Our objective was to determine whether the North Carolina Department of Health and Human Services (State agency) ensured that selected ICF/IIDs in North Carolina that participated in the Medicaid program complied with Federal requirements for life safety, emergency preparedness, and infection control.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

¹ OIG, [Massachusetts Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Emergency Preparedness](#) (A-01-24-0001), Oct. 23, 2024.

Intermediate Care Facilities for Individuals With Intellectual Disabilities

ICF/IIDs are institutions that provide health or rehabilitation services to individuals with intellectual disabilities under the Medicaid program. Services at ICF/IIDs are covered by Medicaid when they are provided in a residential facility licensed and certified by the State survey agency as an ICF/IID. The provision of ICF/IID services is an optional benefit under Medicaid. However, all States offer the benefit as an alternative to home and community-based service waivers for individuals at the ICF/IID level of care. More than 100,000 individuals with intellectual disabilities and other related conditions receive services from ICF/IIDs in the United States.

There are approximately 5,300 Medicaid-certified ICF/IIDs in the United States.² North Carolina has three State-run ICF/IIDs. These three ICF/IIDs are large multi-building facilities operated by the North Carolina Department of Health and Human Services.³

Medicaid Intermediate Care Facilities for Individuals With Intellectual Disabilities Survey Requirements

The Medicaid program covers care in ICF/IIDs for eligible people enrolled in Medicaid. Section 1910 of the Act establishes requirements for CMS and States for the certification of ICF/IIDs. For Medicaid, the statutory participation and survey requirements for ICF/IIDs are implemented in Federal regulations at 42 CFR part 483, subpart I, and 42 CFR part 442, subpart C, respectively.

Requirements for Life Safety, Emergency Preparedness, and Infection Control

ICF/IIDs must comply with all Federal, State, and local laws, regulations, and codes pertaining to health, safety, and sanitation (42 CFR § 483.410), including:

- *Life Safety Requirements:* Federal regulations for life safety (42 CFR § 483.470) require ICF/IIDs to comply with either the Health Care Occupancies Chapter or the Residential Board and Care Occupancies Chapter and must proceed in accordance with the National Fire Protection Association's (NFPA's) Life Safety Code 101 and its Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4). ICF/IIDs that meet the Life Safety Code definition of a health care occupancy must also proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6). CMS lists applicable requirements for health care facilities on Form CMS-2786R, Fire Safety Survey Report.

² We obtained the number of Medicaid-certified ICF/IIDs in the United States from CMS's [Survey and Certification's Quality, Certification and Oversight Reports \(QCOR\)](#). Accessed on Apr. 14, 2025.

³ These three facilities are located on multi-acre campuses that include residential, health care, recreational, educational, and administrative buildings.

- *Emergency Preparedness Requirements:* Federal regulations for emergency preparedness (42 CFR § 483.475) include specific requirements for emergency preparedness plans, policies and procedures, communications plans, training and testing, and integrated healthcare systems. CMS lists applicable requirements on its *Emergency Preparedness Surveyor Checklist*.⁴
- *Infection Control Requirements:* Federal regulations for infection control (42 CFR § 483.470(l)) require ICF/IIDs to have an active program for the prevention, control, and investigation of infection and communicable diseases.

CMS or a designated agency ensures these requirements are met when it conducts a survey of an ICF/IID. The results of each survey are reported and added to CMS's Automated Survey Processing Environment (ASPEN) system.⁵

Responsibilities for Life Safety, Emergency Preparedness, and Infection Control

Federal law requires ICF/IIDs to protect the health, safety, welfare, and rights of ICF/IID residents and to comply with requirements for participating in Medicaid.⁶ CMS is the Federal agency responsible for certifying and overseeing the Nation's approximately 5,300 Medicaid-certified ICF/IIDs. To monitor ICF/IIDs compliance with Medicaid participation requirements, CMS enters into agreements with States under section 1864 of the Act (Section 1864 Agreements).⁷ Under these Section 1864 Agreements, State survey agencies are responsible for conducting surveys to monitor compliance with Federal requirements, including those for life safety, emergency preparedness, and infection control, at least once every 15 months at ICF/IIDs that participate in the Medicaid program.⁸ In North Carolina, the State agency is the State survey agency that oversees ICF/IIDs and is responsible for ensuring that ICF/IIDs comply with Federal, State, and local regulations.

Management and staff at ICF/IIDs are ultimately responsible for ensuring the safety and well-being of their residents and for complying with Federal, State, and local regulations. For example, management and staff are responsible for ensuring that facility systems (e.g., fire, water, kitchen, alarm systems and elevators) are properly installed, tested, and maintained. In

⁴ CMS provides online guidance for emergency preparedness at [Emergency Preparedness Rule](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Surveyor-Tool-EP-Tags.xlsx) and <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Surveyor-Tool-EP-Tags.xlsx>. Accessed on Feb. 21, 2025.

⁵ ASPEN is a suite of software applications designed to help State survey agencies collect and manage health care provider data.

⁶ 42 CFR part 483, subpart I.

⁷ The Act §§ 1864(a), 1902(a)(33), and 1910; CMS's *State Operations Manual*, Pub. No. 100-07, Chapter 1 - Program Background and Responsibilities, sections 1002 and 1004 (Rev. 123, Oct. 3, 2014).

⁸ 42 CFR § 442.109(a).

addition, they are responsible for ensuring that ICF/IIDs are free from hazards, emergency preparedness plans are updated and tested regularly, and the facility has an infection control program.

HOW WE CONDUCTED THIS AUDIT

We conducted unannounced site visits at the three State-run ICF/IIDs during August and September 2024. During each site visit, we checked for life safety violations, reviewed the ICF/IID's emergency preparedness program, and reviewed the ICF/IID's policies and procedures for infection control and prevention. We considered multiple instances of noncompliance with the same Federal requirement to be a single deficiency. For example, if we found three fire extinguishers at one ICF/IID to be in noncompliance with the requirement for monthly testing, we considered it a single deficiency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency could better ensure that ICF/IIDs in North Carolina that participate in the Medicaid program comply with Federal requirements for life safety. The State agency generally ensured that ICF/IIDs in North Carolina complied with Federal requirements for infection control. We did not identify any deficiencies related to emergency preparedness. However, we identified 14 deficiencies related to life safety and infection control. Specifically, we found the following:

- 12 deficiencies across the three ICF/IIDs related to life safety requirements for building exits, fire barriers, and smoke partitions (6); fire detection and suppression systems (4); smoking policies (1); and client bathrooms (1); and
- 2 deficiencies at one facility related to infection control requirements for providing a sanitary environment (1) and keeping records of incidents and corrective actions (1).

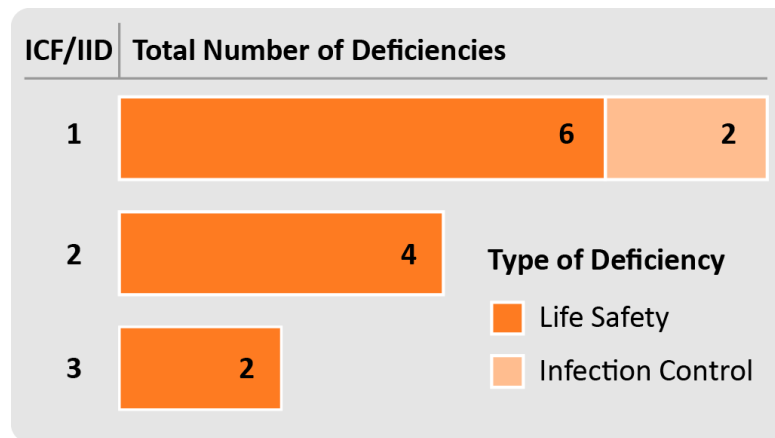
The deficiencies in life safety and infection control occurred because the staff at the three facilities did not continually ensure compliance with applicable life safety and infection control standards. The State Agency said it has procedures in place to address the issues we identified, but persistent education of staff is required to ensure compliance. In addition, although not required by CMS, the State agency did not require relevant staff at ICF/IIDs to participate in

standardized life safety training programs, despite CMS having a publicly accessible online learning portal.

As a result, the health and safety of residents, staff, and visitors at the three ICF/IIDs are at an increased risk of injury or death during a fire or other emergency.

Table 1 summarizes the deficiencies that we identified at each ICF/IID.

Table 1: Summary of All Deficiencies by North Carolina ICF/IID



NORTH CAROLINA INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES DID NOT COMPLY WITH LIFE SAFETY REQUIREMENTS

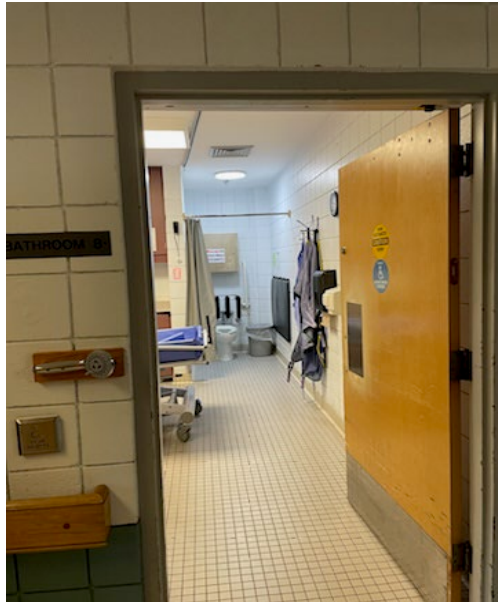
CMS's Fire Safety Survey Report form (Form CMS-2786R), described in the Background section above, lists the Federal requirements on life safety that ICF/IIDs surveyed under health care must comply with and references each with an identification number, known as a K-Tag (numbered K-100 through K-933).⁹

Building Exits, Fire Barriers, and Smoke Partitions

In case of fire or emergency, ICF/IID buildings surveyed under existing healthcare occupancy must have unobstructed exits, self-closing doors in exit passageways that are not manually propped open, no horizontal sliding doors without a latch or other mechanism to prevent rebound, and fire-stopped smoke and fire barriers (K-Tags 211, 223, 224, and 372).

⁹ The State agency uses Form CMS-2786R to conduct life safety surveys of most buildings that comprise the three ICF/IID campuses.

All three ICF/IIDs had deficiencies related to building exits, fire barriers, and smoke partitions, totaling six deficiencies. Specifically, we found deficiencies related to exits that were not free of obstructions or impediments (one ICF/IID). In addition, we found deficiencies involving doors with self-closing devices that either did not close completely (one ICF/IID) and manual horizontal sliding doors with no mechanism to prevent rebound (one ICF/IID). Lastly, we found deficiencies related to penetrations in smoke or fire barriers, including missing and broken ceiling tiles and holes in the ceiling and walls (three ICF/IIDs). The photographs below depict some of the deficiencies we identified during our site visits.



Automatic Door Propped Open



Missing Ceiling Tiles



Missing Ceiling Tiles

Fire Detection and Suppression Systems

ICF/IIDs must have cooking equipment that is protected in accordance with NFPA 96, which provides preventative and operative fire safety requirements intended to reduce potential fire hazards. ICF/IIDs must also have sprinkler systems installed according to NFPA requirements. In addition, staff at ICF/IIDs must inspect portable fire extinguishers monthly (K-Tags 324, 351, and 355).

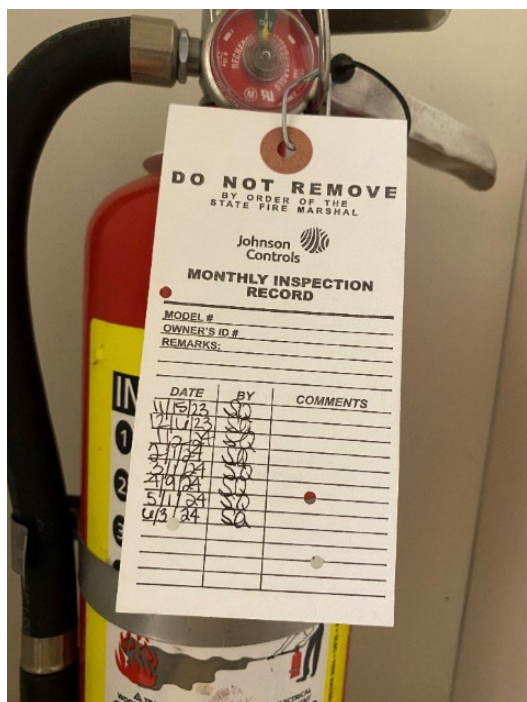
Two of the ICF/IIDs we inspected had deficiencies related to their fire detection and suppression systems, totaling four deficiencies. Specifically, we found one ICF/IID with missing exhaust vent covers in the kitchen. One ICF/IID had deficiencies related to blocked or obstructed sprinkler heads. We also found that two ICF/IIDs had portable fire extinguishers that were not inspected monthly. The photographs below depict some of the deficiencies we identified during our site visits.



Missing Vent Cover



Blocked Sprinkler Head

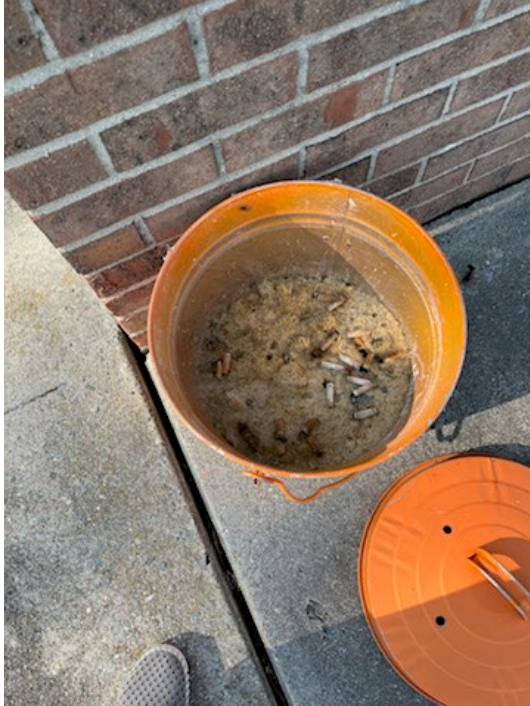


**Fire Extinguisher Missing Monthly Inspections
at the Time of our September Site Visit**

Smoking Policies

ICF/IIDs must establish smoking policies for residents and staff. Ashtrays of non-combustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available in areas where smoking is permitted (K-Tag 741).

Effective, July 2015, the North Carolina Mental Health Commission amended a rule to prohibit tobacco use anywhere on the grounds of State-operated healthcare facilities. Therefore, all three ICF/IIDs were non-smoking campuses. However, because each of the three facilities had residents who smoked prior to this amended rule, these residents were allowed to continue smoking in designated areas. We found that one ICF/IID had deficiencies related to ashtrays that were not made of non-combustible material and safe design, and cigarette butts found in non-designated areas, totaling one deficiency. The photograph on the next page depicts an example of the deficiency we identified during our site visits.



Cigarette Butts in Non-Designated Area and in Unapproved Receptacle

Client Bathrooms

ICF/IIDs must ensure the temperature of water does not exceed 110 degrees Fahrenheit in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water (W Tag 426).

One of the ICF/IIDs had a deficiency related to client bathrooms because hot water temperatures exceeded 110 degrees Fahrenheit. The photograph below depicts the deficiency we identified during our site visit.



Water Temperature Exceeding 110-Degree Limit

Table 2 summarizes the life safety deficiencies that we identified at each ICF/IID.

Table 2: Life Safety Deficiencies

ICF/IID	Number of Life Safety Deficiencies			
1	2	3	1	
2	2	1	1	
3	2			
Type of Life Safety Deficiency <ul style="list-style-type: none"> Building Exits, Fire Barriers, & Smoke Partitions Fire Detection & Suppression Systems Smoking Policies Client Bathrooms 				

NORTH CAROLINA INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES GENERALLY COMPLIED WITH INFECTION CONTROL REQUIREMENTS

Infection Control Program

ICF/IIDs must provide a sanitary environment to avoid sources and transmission of infections. An active program for the prevention, control, and investigation of infection and communicable diseases is required. ICF/IIDs also must maintain a record of incidents and corrective actions related to infections (W-Tags 454, 455, 457).

We found no deficiencies at two of the ICF/IIDs we reviewed. However, one ICF/IID had multiple instances of possible mold present in multiple ceiling tiles.¹⁰ This same ICF/IID also had a deficiency related to their records of incidents and corrective actions related to infections. Specifically, the ICF/IID did not have a documented corrective action plan.

Table 3 summarizes the infection control deficiencies that we identified at each ICF/IID.

Table 3: Infection Control Deficiencies

ICF/IID	Number of Infection Control Deficiencies
1	2
2	0
3	0

CONCLUSION

After of our inspections, we shared the deficiencies we identified with the management and staff of the ICF/IIDs we inspected so that they could take immediate corrective action. We also shared the deficiencies with the State agency for follow-up inspections, as appropriate. Although management and staff at ICF/IIDs are responsible for ensuring resident safety, the State agency could better ensure that ICF/IIDs comply with Federal health and safety requirements.

¹⁰ During our inspections, we spotted signs of mold at two facilities. One facility provided records showing there was no mold in that facility. However, the facility mentioned in this report had no such records available.

RECOMMENDATIONS

We recommend that the North Carolina Department of Health and Human Services:

- verify that the three ICF/IIDs we inspected have taken corrective actions on the life safety and infection control deficiencies identified during the audit;
- work with the applicable ICF/IID to determine whether mold exists; and
- work with CMS to develop standardized life safety training for staff at ICF/IIDs.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our first two recommendations and described actions it had taken to address them. The State agency neither concurred nor non concurred with our third recommendation. Specifically:

- Regarding our first recommendation, the State agency summarized the corrective actions it took because of the life safety and internal control deficiencies identified by OIG. A number of these actions had already been addressed during follow-up surveys by the State agency. The State agency also provided explanations where they disagreed with deficiencies related to horizontal sliding doors, missing and cracked ceiling tiles, missing vent covers, and self-closing doors.
- Regarding our second recommendation, the State agency stated it conducted testing for mold and noted positive results in limited areas. The State agency completed roof repairs for water intrusion and procured testing and assessment equipment for each facility. The State agency also provided training to all facility staff on air quality and testing. The State agency noted that repairs had been made to the leaking roof, the ceiling tiles had been replaced, and the mold had been removed.
- Regarding our third recommendation, the State agency stated that while it supports working with CMS to execute all training requirements and additional training opportunities for staff at ICF/IID facilities, no federal requirements exist for the survey agency or the ICF/IID facilities to develop training regarding federal life safety.

OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate the State agency's cooperation throughout our audit and the actions it has taken to swiftly address our recommendations. With respect to our first recommendation and the life

safety deficiencies with which the State agency disagreed, we maintain all life safety deficiencies in this report are valid. Specifically, K224 requires that horizontal sliding doors be “operable from either side without special knowledge or effort” and the doors identified as noncompliant in this report only had handles on one side of the door. The self-closing doors we identified in our report did not close completely as shown in the picture we took. And although the State agency did not agree with some of the noncompliant instances we observed, we appreciate the State correcting some of the instances, such as the missing and damaged ceiling tiles. We commend the State agency for taking action regarding our second recommendation. With respect to our third recommendation, as stated in this report, although not required, we continue to encourage the State agency to work with CMS to develop standardized life safety training for staff as one avenue to increase staff awareness and reduce the risks to residents.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We did not assess the State agency's overall internal control structure. Rather, we limited our assessment of internal controls to those applicable to our audit objective. Specifically, we assessed the State agency's policies, procedures, and practices applicable to monitoring ICF/IIDs' compliance with life safety, emergency preparedness, and infection control requirements.

We conducted unannounced site visits at the State's three ICF/IIDs from August through September 2024.

METHODOLOGY

To accomplish our objective, we took the following steps:

- reviewed applicable Federal and State requirements;
- reviewed recent deficiency reports prepared by the State agency for the ICF/IIDs;
- conducted unannounced site visits at the ICF/IIDs to check for life safety violations, review the ICF/IIDs' emergency preparedness programs, and review the ICF/IIDs' infection control policies and procedures; and
- discussed the results of our inspections with the ICF/IIDs and the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Maine Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control</i>	A-01-24-00004	6/16/25
<i>Massachusetts Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Emergency Preparedness</i>	A-01-24-00001	10/23/2024
<i>Massachusetts Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control</i>	A-01-23-00003	10/4/2024
<i>Colorado Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control</i>	A-07-22-07009	2/2/2024
<i>Oklahoma Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control</i>	A-06-22-09007	1/4/2024
<i>Ohio Could Better Ensure That Nursing Homes Comply With Federal Requirement for Life Safety, Emergency Preparedness, and Infection Control</i>	A-05-22-00019	12/20/2023
<i>Washington State Did Not Ensure That Selected Nursing Homes Complied With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control</i>	A-09-22-02006	12/8/2023
<i>Pennsylvania Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection control</i>	A-03-22-00206	11/8/2023
<i>New Jersey Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control</i>	A-02-22-01004	9/29/2023
<i>Georgia Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control</i>	A-04-22-08093	9/6/2023
<i>Audits of Nursing Home Life Safety and Emergency Preparedness in Eight States Identified Noncompliance With Federal Requirements and Opportunities for the Centers for Medicare & Medicaid Services to Improve Resident, Visitor, and Staff Safety</i>	A-02-21-01010	7/15/2022
<i>North Carolina Should Improve Its Oversight of Selected Nursing Homes' Compliance with Federal Requirements for Life Safety and Emergency Preparedness</i>	A-04-19-08070	09/18/2020

APPENDIX C: STATE AGENCY COMMENTS

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor

DEVDDUTTA SANGVAI • Secretary

KAREN BURKES • Deputy Secretary for Licensing and Facilities

NIKI ASHMONT • Acting DSOHF Director

June 16, 2025

Via email @ Truman.Mayfield@oig.hhs.gov

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Regional Inspector General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Re: Report Number: A-04-24-02504

Dear Mr. Mayfield:

The North Carolina Department of Health and Human Services (NC DHHS), Division of Health Service Regulation (DHSR) and Division of State Operated Healthcare Facilities (DSOHF) appreciate the opportunity to review and comment on this Office of Inspector General (OIG) draft report entitled: *North Carolina Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Infection Control*.

The safety of residents in North Carolina's Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) is a top priority for NCDHHS. As the State Survey Agency (SA), NC DHHS' DHSR, on behalf of the Centers for Medicare and Medicaid Services (CMS), surveys ICF/IID facilities that participate in the Medicare or Medicaid programs to determine the facility's compliance with CMS and State requirements, including requirements regarding life safety and infection control. DHSR works closely with CMS to understand CMS' requirements for these facilities as well as CMS' requirements and expectations for the SA as it conducts its survey work on behalf of CMS. NC DHHS' DSOHF is responsible for the management and operations of the State operated ICF/IIDs in North Carolina and for ensuring compliance with all applicable regulations.

NC DHHS appreciates the professionalism of each OIG staff member we interacted with during this audit. We have reviewed your draft report and offer the following general observation at the outset:

NC SA Surveyor Expertise

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF STATE OPERATED HEALTHCARE FACILITIES

LOCATION: 803 Biggs Drive, Clark Building, Raleigh, NC 27603
MAILING ADDRESS: 3006 Mail Service Center, Raleigh, NC 27699-3006
www.ncdhhs.gov • TEL: 919-855-4700 • FAX: 919-508-0955

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

The NC SA surveyors that conduct the CMS life safety code and infection control surveys go through a rigorous training process including learning the federal regulations and the CMS guidance and interpretations regarding the federal regulations. North Carolina's SA Life Safety Code (LSC) surveyors are required to complete a number of CMS-required courses as well as undergo training provided by DHSR.

The purpose for noting the significant education and training of the SA's surveyors is because the SA disagrees with several items the OIG identified as noncompliant. NC DHHS believes its trained surveyors have expertise in these matters and have correctly interpreted the federal requirements. In its response below, NC DHHS identifies some of the items OIG identified as noncompliant with which we respectfully disagree.

The following represents North Carolina's response and corrective action plan to the three OIG recommendations:

OIG RECOMMENDATIONS

OIG recommends NC DHHS:

1. Verify that the three ICF/IIDs we inspected have taken corrective actions on the life safety and infection control deficiencies identified during the audit.

NC DHHS Response: Concur.

Many of the items identified by the OIG auditors were corrected by the DSOHF ICF/IID facility staff immediately upon identification by OIG. Once the SA learned of the items the OIG identified as noncompliant, the SA conducted follow-up life safety surveys at each DSOHF ICF/IID facility to investigate each item identified by the OIG. The follow-up surveys ICF/IID 3, ICF/IID 1, and ICF/IID 2 occurred on 12/13/2024, 12/17/2024, and 1/28/2025 respectively. Although NC's SA concurs that a number of the following items were correctly identified as noncompliant, there are items that OIG identified as noncompliant with which NC's SA disagrees. Following is a summary of the corrective action that DSOHF has undertaken that NC's SA has verified, or an explanation as to why NC's SA disagrees with the OIG's identification of the item as noncompliant:

ICF/IID 1

- **Horizontal sliding doors**

OIG identified as noncompliant bathroom sliding doors in two buildings.

These doors are compliant. These are doors to shower cubicles inside the bathroom. A latch is not required on doors in this location. NFPA 101 [2012] 19.3.6.3.2 (1) states "[d]oors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall not be required to comply with 19.3.6.3.1."

- **Penetrations in smoke/fire barrier**

OIG identified as noncompliant, holes in ceiling tiles in two buildings.

DSOHF maintenance staff were aware of the missing/damaged/stained ceiling tiles in one of those buildings and stated after the roof replacement was complete, missing/damaged/stained ceiling tiles would be replaced. However, the holes in these suspended ceiling tiles were compliant fire barriers and therefore not a deficiency. These suspended ceiling tiles are ornamental to screen building services (ducts/pipes/wires) from view and are not part of a smoke or fire barrier. Nonetheless, stained and broken ceiling tiles are being replaced by DSOHF. Similarly in the other building, the missing/damaged/stained ceiling tiles were compliant fire barriers. These suspended ceiling tiles are ornamental to screen building services from view and are not part of a smoke or fire barrier. Stained and broken ceiling tiles are being replaced by DSOHF staff.

- **Cooking facilities**

OIG identified as noncompliant open circular holes in ceilings, likely exhaust vents missing covers. DSOHF maintenance staff stated during cleaning the covers are sometimes removed/accidentally knocked off. This is not a deficiency based on the fact that the covers are ceiling diffuser airflow inserts and not integral to the smoke or fire resistance rating of the ceiling assembly. Nonetheless, these covers were replaced by DSOHF staff during DHSR's survey.

- **Sprinkler system installation**

OIG identified noncompliance in three buildings.

DHSR verified that as to the obstructed ceiling hoist mounting in the first building a shower room the ceiling hoist was not properly returned to its docking station. The ceiling track systems in these facilities are movable via integral electric motors and can traverse the entire room to position individuals in the bathing area. DSOHF's Director of Facility Maintenance confirmed that on the day of the OIG inspection he performed an in-service with all staff and management to instruct proper operation, storing and charging protocols. DSOHF's operational policy is to not leave hoist or track components in any location that would impede sprinkler flow. After use, the track and hoist are returned to the home position which provides clearance. In another building, the facility has removed the obstruction to the sprinkler head. In the third building, the sprinkler head has been replaced.

- **Fire Extinguisher**

OIG noted there were two (2) fire extinguishers that did not have monthly and/or annual inspection dates. The SA notes it cited this deficiency during the 11/13/2024 Life Safety Survey. The SA verified the facility's corrective action which was to send a campus-wide email to all households reminding them of this requirement.

- **Smoking regulations**

The OIG noted that a resident who is a smoker lives in one building, but the facility had no signage for designated smoking area nor was there a receptacle to put out cigarettes near that building. The SA verified an approved, fire safe receptacle was installed.

In another building, the OIG identified a noncompliant cigarette receptacle. DHSR verified during its 12/17/2025 follow-up inspection, that the noncompliant cigarette receptacle has been removed.

- **Infection Control**

See OIG Recommendation #2 below regarding its reference to incidents of possible mold being present in multiple ceiling tiles and DSOHF's testing and remediation of the area at the facility.

The OIG noted a deficiency related to this facility's records of incidents and corrective actions related to infections. Specifically, the OIG noted the facility did not have a documented corrective action plan. DSOHF revised its infection control action plan to specify that the infection control assessment includes issue notes, correction to be taken, responsible person, and completion date to better track issues and corrections. This change was approved by DHSR to correct the deficiency noted.

ICF/IID 2

- **Means of egress**

The OIG noted nightstand that was partially blocking exit door. During its 1/28/2025 follow-up inspection, the SA verified the nightstand had been moved so it no longer partially blocked the exit door.

- **Penetrations in smoke/fire barrier**

The OIG identified cracks/holes in suspended ceiling tiles as noncompliant. As noted above under the response to the OIG's deficiencies found at ICF/IID 1, this is compliant. These suspended ceiling tiles are ornamental to screen building services from view and are not part of a smoke or fire barrier. Nonetheless, stained and broken ceiling tiles were replaced by DSOHF and their replacement verified during the SA's 1/28/2025 follow-up inspection.

The OIG identified holes in ceiling tiles in the kitchen area. As explained previously, this is not a deficiency. These suspended ceilings and tiles are ornamental to screen building services from view and are not part of a smoke or fire barrier. Nonetheless, the SA verified that the damaged tiles had been replaced by DSOHF.

- **Portable fire extinguishers**

The OIG noted a fire extinguisher that had not been inspected in 2 months. The SA verified during the 1/28/2025 follow-up inspection that the fire extinguishers had been inspected.

The OIG noted the exterior of closet had signage indicating fire extinguisher, but the fire extinguisher could not be located because a sheet was covering the fire extinguisher. The SA has verified the facility's corrective action of removing the sheet.

- **Client bathrooms**

The OIG noted water temperatures of 119 degrees, higher than the max 115 degrees. During the 1/28/2025 follow-up inspection, the SA verified the facility had taken corrective action to reduce the water temperature to an acceptable range.

ICF/IID 3

- **Doors with self-closing devices**

The OIG identified eight (8) automatic doors held open by a release device that neither opened nor closed automatically as noncompliant. This is not a deficiency. These are smoke doors actuated by the fire alarm. These doors are tested annually (the most recent test occurred on 9/13/2024) by Everon Fire Safety and during the annual Life Safety Survey (most recently, on 10/10/2024).

Since none of the issues identified above by the OIG are noncompliant with federal or state requirements, no corrective action is necessary.

- **Penetrations in smoke/fire barrier**

In two buildings, the OIG identified ceiling tiles with holes and cracks. This is not a deficiency. Suspended ceilings and tiles are ornamental to screen building services from view and are not part of a smoke or fire barrier. Nonetheless, the damaged tiles have been replaced by DSOHF as was verified by the SA during the 12/13/2024 follow-up inspection.

DHSR will continue to monitor compliance through routine surveys and work collaboratively with DSOHF and each individual ICF/IID to promptly address any future deficiencies.

2. *Work with the applicable ICF/IID to determine whether mold exists.*

NC Response: Concur.

Following the OIG audit, DSOHF conducted testing for mold. Positive results were noted in limited areas and were temporarily mitigated while roof repairs for water intrusion were completed. Testing and assessment equipment were procured by DSOHF for each facility and NC DHHS Safety Officers provided training to all facility staff in March on air quality and testing. The SA has verified that repairs have been made to the leaking roof, ceiling tiles replaced, and the mold removed.

3. *Work with CMS to develop standardized life safety training for staff at ICF/IIDs.*

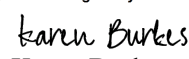
NC Response: Neither concurrence nor nonconcurrence.

NC's SA will continue to work closely with CMS to support and execute all training that CMS requires and will also continue to provide consultative assistance to facilities. While NC DHHS is supportive of additional training opportunities for staff at ICF/IID facilities, there is no federal requirement for the SA or the ICF/IID facilities to develop training regarding federal life safety training.

Thank you again for the opportunity to review and comment on this draft report. If you need any additional information, please feel free to contact me.

Sincerely,

DocuSigned by:


Karen Burkus

cc: Amelia Wentz, OIG Assistant Regional Inspector General for Audit
Mark Payne, Director, Division of Health Services Regulation
Emery Milliken, Deputy Director, Division of Health Services Regulation
Niki Ashmont, Acting Director, Division of State Operated Healthcare Facilities
Jeff Harms, Chief, Construction Section, Division of Health Service Regulation
Julie Cronin, General Counsel

Jeff Grimes, Director, Office of the Internal Auditor

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