

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2026	
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5706 14TH STREET, NW, WASHINGTON, District of Columbia, 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E0000	Initial Comments An emergency preparedness survey was conducted at this facility from 08/26/2026 through 08/28/2026. The findings of the survey were based on observations, interviews and a review of the facility's emergency preparedness program.	E0000	Please start typing your responses here:		
W0000	INITIAL COMMENTS A recertification survey in conjunction with a complaint investigation survey was conducted at this facility from 08/26/2026 through 08/28/2026. A sample of two clients was selected from a census of four. The survey was conducted utilizing the full survey process. The findings of the survey were based on observations, interviews, and record reviews.	W0000			
E0030	Names and Contact Information CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians	E0030			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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E0030	Continued from page 1 (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following:	E0030			

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E0030	Continued from page 2 (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is NOT MET as evidenced by: Based on observations, interviews and review, the facility communication plan (CP) failed to include current names and contact information of each staff, for two of the eight direct support professionals (DSP) and one Licensed Practical Nurse (LPN) observed in the facility (DSPs #5, #7 and LPN). Findings Included: Observations on 08/26/2026 beginning at 8:07 AM showed the LPN administering medications to Client #3. Again on 08/27/2026 at 6:12 PM, observations showed the LPN administering evening medications to Client #2.	E0030			

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E0030	Continued from page 3 On 08/27/2026 at 6:20 PM, a review of the facility's CP showed no evidence that the contact list of the DSPs had been updated to include the contact information for DSPs #5, #7 and the LPN. Further review of the list revealed that the facility failed to remove the names of the old Qualified Intellectual Disabilities Professional (QIDP), the Residential Coordinator (RC), Program Director and several DSPs from their contact list. On 08/28/2026 beginning at 12:28 PM, review of the personnel files maintained for the two DSPs observed working in the facility on 08/26/2026, 08/27/2026 and 08/28/2026 revealed that DSPs #5 and #7 were hired during the 2026 calendar year. During an interview on 08/28/2028 at 3:40 PM, the QIDP when asked about the CP and contact information for staff on, reviewed the contact information and acknowledged that it did not reflect the DSPs and the LPN who had been hired after the initial CP was developed. The also acknowledged that older staff contact information should be removed from the CP.	E0030			
W0125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is NOT MET as evidenced by: Based on interview and record reviews, the facility failed to allow each client to exercise their right regarding answering the telephone, for one of the two clients in the sample (Client #1). Findings Included: The review of an incident report dated 08/09/2026 at 3:30 PM, revealed that Direct Support Professional (DSP) #8 while sitting at the dining room table going through notes heard the telephone ring, and proceeded to the living room to pick up the phone. Per the report, Client #1 who was sitting on the couch in the living room rushed to pick up the telephone to answer the call, but DSP #8 stopped the client from answering the telephone and told the client, "that's not her responsibility." According to	W0125			

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W0125	Continued from page 4 the incident report, Client #1 became angry and exhibited verbally aggressive behaviors.	W0125			
W0159	The Qualified Intellectual Disabilities Professional (QIDP) during an interview on 08/26/2026 at 3:04 PM, regarding the incident, stated that DSP #8 stopped Client #1 from answering the house phone, and Client #1 became angry and started exhibiting verbal aggressive behaviors towards the DSP. DSP #8 then called the Residential Coordinator (RC) to help calm the client down. When asked, the QIDP stated that Client #1 was very capable of answering the telephone and DSP #8 should not have stopped her from doing so. QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is NOT MET as evidenced by: Based on interview, and record reviews, the facility failed to ensure that each Direct Support Professionals (DSP #8) received initial and ongoing training regarding each client Behavior Support Plan (BSP), for one of the two clients in the sample (Client #1). Findings Included: A review of Client #1's BSP dated 06/04/2026 revealed that the client had a targeted behavior of Verbal Aggression, defined as screaming, yelling and cursing at staff and peers. The review of an incident report dated 08/09/2026 at 3:30 PM, revealed that Direct Support Professional (DSP) #8 while sitting at the dining room table going through notes heard the telephone ring, and proceeded to the living room to pick up the phone. Per the report, Client #1 who was sitting on the couch in the living room rushed to pick up the telephone to answer the call, but DSP #8 stopped the client from answering the telephone and told the client, "that's not her responsibility." According to the incident report, Client #1 became angry and exhibited verbally aggressive behaviors. The Qualified Intellectual Disabilities Professional (QIDP) during an interview on 08/26/2026 at 3:04 PM, regarding the incident, stated that DSP #8 stopped Client #1 from answering the house phone, and Client #1 became angry and started exhibiting verbal aggressive behaviors towards the DSP. DSP	W0159			

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W0159	Continued from page 5 #8 then called the Residential Coordinator (RC) to help calm the client down. When asked, the QIDP stated that Client #1 was very capable of answering the telephone and DSP #8 should not have stopped her from doing so. The QIDP when asked if DSP #8 had received training on client's rights and dignity and on Client #1's Behavior Support Plan (BSP) prior to working at this facility, the stated, "No". Per the QIDP, DSP #8 was later trained on the client's rights which included clients' answering the telephone and the BSP after the incident. On 08/28/2026 at 3:20 PM, a review of the facility's in-service training record confirmed that DSP #8 received initial training on 08/26/2026 regarding Client #1's BSP.	W0159			
W0189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is NOT MET as evidenced by: Based on interview, and record reviews, the facility failed to ensure that each Direct Support Professionals (DSP #8) received initial and ongoing training regarding each client Behavior Support Plan (BSP), for one of the two clients in the sample (Client #1). A review of Client #1's BSP dated 06/04/2026 revealed that the client had a targeted behavior of Verbal Aggression, defined as screaming, yelling and cursing at staff and peers. The review of an incident report dated 08/09/2026 at 3:30 PM, revealed that Direct Support Professional (DSP) #8 while sitting at the dining room table going through notes heard the telephone ring, and proceeded to the living room to pick up the phone. Per the report, Client #1 who was sitting on the couch in the living room rushed to pick up the telephone to answer the call, but DSP #8 stopped the client from answering the telephone and told the client, "that's not her responsibility." According to the incident report, Client #1 became angry and exhibited verbally aggressive behaviors. The Qualified Intellectual Disabilities Professional	W0189			

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W0189	Continued from page 6 (QIDP) during an interview on 08/26/2026 at 3:04 PM, regarding the incident, stated that DSP #8 stopped Client #1 from answering the house phone, and Client #1 became angry and started exhibiting verbal aggressive behaviors towards the DSP. DSP #8 then called the Residential Coordinator (RC) to help calm the client down. When asked, the QIDP stated that Client #1 was very capable of answering the telephone and DSP #8 should not have stopped her from doing so. The QIDP when asked if DSP #8 had received training on client's rights and dignity and on Client #1's Behavior Support Plan (BSP) prior to working at this facility, the stated, "No". Per the QIDP, DSP #8 was later trained on the client's rights which included clients' answering the telephone and the BSP after the incident. On 08/28/2026 at 3:20 PM, a review of the facility's in-service training record confirmed that DSP #8 received initial training on 08/26/2026 regarding Client #1's BSP.	W0189			
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is NOT MET as evidenced by: Based on observations, interview, and record reviews, the facility failed to ensure that each client's active treatment program (i.e. self-medication program) was implemented as recommended, for one of the two clients in the sample (Client #2). Findings Included: A review of Client #2's Individual Program Plan (IPP) dated 01/09/2026 indicated the following objective: "Daily, [client name] will recite the purpose of taking Lipitor every evening for hypercholesterolemia with 100% of the opportunities presented for 12 months." The IPP showed the following action steps:	W0249			

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W0249	Continued from page 7 1. The Trained Medication Employee (TME)/nurse will inform [client name] that it is time to take her pm medications. 2. The TME/nurse will ask [client name] to recite the purpose of her taking Lipitor 10 mg (1 tablet) every evening for hypercholesterolemia. 3. Staff will provide any support needed for [client name] to successfully achieve the goal. Observations on 08/27/2026 at 6:12 PM, showed Client #2 retrieved a cup of water after washing her hands, and walked downstairs to the basement to receive her evening medications. The Licensed Practical Nurse (LPN) prepared and handed the clients medications which included Lipitor 10 mg which Client #2 consumed the medications and drank her water independently. At no time did the LPN ask Client #2 to recite the purpose of taking Lipitor. The LPN at 6:17 PM, when asked if Client #2 had a self-medication program, stated, "No, I just have her take her to rinse her mouth out using the prescribed mouth wash independently with supervision." During an interview on 08/28/2028 at 12:50 PM, the Registered Nurse (RN) also stated that Client #2 did not have a self-medication program. When the surveyor shared that the client had an IPP objective to recite the purpose of Lipitor during the evening, the RN indicated that she would follow up with the LPN and the Qualified Intellectual Disabilities Professional (QIDP), and that she was under the impression that the Direct Support Professionals (DSPs) were responsible for implementing the self-medication program. The QIDP in an interview at 3:30 PM, regarding Client #2's self-medication program stated that the program should be implemented by the evening nurse. When asked if the nursing staff including the RN were aware that the nurse was to implement the self-medication program during the evening, the QIDP said, "No". A review of the facility's in-service training records at 3:33 PM revealed that on 08/14/2026, the Direct Support Professionals (DSP) received training on Client #2 IPPs goals and objectives. However, the LPN was not a part of the training. At 3:40 PM, the QIDP said during an interview that the LPN had not been made aware of Client #2's self-medication program.	W0249			

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W0426	CLIENT BATHROOMS CFR(s): 483.470(d)(3) The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is NOT MET as evidenced by: Based on observations, interview and record reviews, the facility failed to ensure that hot water temperatures did not exceed 110 degrees Fahrenheit (°F) throughout the facility (kitchen sink and client bathrooms) for the four clients residing in the facility (Clients #1, #2, #3 and #4). Findings Included: Observations on 08/28/2025 beginning at 1:23 PM, during the environmental inspection of the facility revealed that the kitchen sink water felt hot to touch. A check of the water temperatures throughout the facility showed the following readings: -Kitchen Sink reading was 122:3°F; -Clients #3 and #4 bathroom sink 119.8°F; -Clients #1 and #2 bathroom sink reading was 121:8°F; and -Basement sink reading was 122 °F. At 1:57 PM, the Residential Coordinator (RC), who accompanied the surveyor during the inspection confirmed the high hot water temperatures and called the maintenance technician regarding the hot water temperatures above 110°F throughout the facility. When asked what the process was when water temperatures exceeded 110 (°F), the RC stated that the staff should document and report the temperatures to me. The RC also confirmed that all staff had been trained in checking and documenting the water temperature logs. Additionally, the RC stated that she was in the process of developing a water temperature logbook because there was no water temperature logbook available when she started a couple months ago. At 4:15 PM, the maintenance staff arrived at the facility and adjusted the gauge on the hot water heater. The maintenance technician stated that he was on his way back to the facility to adjust the hot water. After waiting for at least 45 minutes, maintenance staff rechecked the hot water			W0426			

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W0426	Continued from page 9 temperatures in the kitchen, basement and the clients' and the hot water temperature ranged from 107°F and 108.1°F.	W0426			
W0440	EVAUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is NOT MET as evidenced by: Based on interview and record reviews, the facility failed to conduct quarterly evacuation drills as required for the five shifts of duty reviewed. (Weekday morning 8:00 AM to 4:00 PM, evening 4:00 PM to 12:00 AM and overnight 12:00 PM to 8:00 AM and Weekend morning 8:00 AM to 8:00 PM and Evening 8:00 PM to 8:00 AM), for four of four persons residing in the facility (Persons #1, #2, #3 and #4). Findings Included: During an interview on 08/26/2026 at 12:14 PM, the Residential Coordinator (RC) indicated that the facility has five designated shifts (8:00 AM to 4:00 PM; 4:00 PM to 12:00 AM; 12:00 AM to 8:00 AM), Monday through Friday and (8:00 AM to 8:00 PM and 8:00 PM to 8:00 AM) on the weekend (Saturday/Sunday). On 08/27/2026, beginning at 12:16 PM, a review of the facility's fire drill records, revealed the following: - There were no drills conducted during the weekday morning shift (8:00 AM to 4:00 PM) from October 2025 through March 2026. -There were no drills conducted during the weekday evening shift (4:00 PM to 12:00 PM) from October 2025 through March 2026. - There were no drills held during the weekday overnight shift 12:00 AM to 8:00 AM) from October 2025 through March 2026. - There were no drills held during the weekend morning shift (8:00 AM to 8:00 PM) from October 2025 through March 2026. - There were no drills held during the weekend evening shift (8:00 PM to 8:00 AM) July 2026 through March 2026. The RC at 12:38 PM after reviewing the fire drill reports acknowledged the findings. The RC stated	W0440			

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W0440	Continued from page 10 that she would contact the office to see if additional fire drill records were stored there. There was no additional fire drills made available for review by the time the survey ended on 08/28/2026.	W0440			