

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CPA-050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2014
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NAME OF PROVIDER OR SUPPLIER ADOPOLIS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5247 WISCONSIN AVENUE, NW WASHINGTON, DC 20015
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(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) COMPLETE DATE
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S 000	<p>Initial Comments</p> <p>The Department of Health, Health Regulation and Licensing Administration conducted a monitoring survey on March 25, 2014. The focus of this survey was to determine continued compliance with local licensure requirements.</p> <p>The survey findings were based on interview and the review of administrative and personnel records. The sample size was three personnel records based on a census of three (3) employees, three home study records based on a census of three(3).</p> <p>The agency was is in compliance with the requirements of Title 29, Chapter 16, Standards of Placement, Care and Services for Child Placing Agencies. There were no deficiencies found at the time of this survey.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____