

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CPA-050</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/17/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADOPOLIS, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5247 WISCONSIN AVENUE, NW WASHINGTON, DC 20015</b>
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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>An annual licensure survey was conducted on 04/17/19. The survey findings were based on interview, review of administrative records, as well as personnel records, which included 3 employees, five board member records and one adoption family records.</p> <p>There were no deficiencies identified during the inspection. The Agency was found to be in substantial compliance with Title 29 Chapter 16, Standards of Placement, Care and Services for Child-Placing.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_