☐ Initial ☐ Unannounced Full/Partial ☑ Follow-up ☐ Location Change ☐ Investigation ☐ Other_____

SUPPLEMENTAL REPORT OF INSPECTION

Name of Program/Provider: Kids Castle Childcare Learning Center Date: 6/17/22 Time: 2:00

Location Address: 10 Commerce Rd. Newtown Telephone #: 203-270-6771

e-mail address: kidscastlect@gmail.com License #: 70605 Expiration Date: 3/31/25

Capacity: 94/48 # of Children Present: 27 # of Staff Present: 5(1)

Consent to Inspect Family Child Care Home	*I agree to allow the Office of Early Childhood to have access to and inspect this facility and all child care records as required by Family Child Care Home Regulations.* ***Provider/Applicant/Substitute's Signature*** _____

Purpose of visit: follow up on ratio + safe sleep

Observations/Corrections needed:

In compliance 4:1

4:1

discussed: 8:2

- observed infant sitting on floor drinking 8:1

a bottle - not held for bottle feedings. 3:1

S = Substantiated NS = Not Substantiated P = Pending (if applicable)

Operators/providers are required by regulations and statutes to be in compliance at all times.

CORRECTIVE PLAN SHALL BE RETURNED TO OEC BY: N/A

Signature: _____
(OEC Representative)

Print Name: Kristin Morgan

Signature: Donna Kroha
(Person in Charge)

Print Name: Donna Kroha