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

SUPPLEMENTAL REPORT OF INSPECTION

Name of Program/Provider: Christina Anastasio Date: 3/29/23 Time: _____

Location Address: 56 Hillside Dr. Beacon Falls, Ct Telephone #: 203-298-8040

e-mail address: Christinaanastasio16@gmail.com License #: 57104 Expiration Date: 10/31/24

Capacity: 6+3 # of Children Present: 6 # of Staff Present: 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*** Christina Anastasio

Purpose of visit: Follow up to safe sleep

Observations/Corrections needed:

Upon my arrival, all children were napping. No children had bottles in cots and pack-n-play.

Provider is in compliance with safe sleep.

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

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

Signature: Jannie Thornton
(OEC Representative)
Jannie Thornton

CORRECTIVE PLAN SHALL BE RETURNED TO OEC BY: _____

Signature: Christina Anastasio
(Person in Charge)
Christina Anastasio