

Initial Unannounced Full/Partial Follow-up Location Change Investigation Other _____

SUPPLEMENTAL REPORT OF INSPECTION

Name of Program/Provider: Hudson Country Montessori Date: 5/31/23 Time: 1:50

Location Address: 44A Shelter Rock Rd. Telephone #: 203-744-8088

e-mail address: Megan@hudsoncountry.org License #: 14818 Expiration Date: 1/31/24

Capacity: 197/75 # of Children Present: 130 # of Staff Present: 16(3)

**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 to full inspection on 5/31/23

Observations/Corrections needed:

<u>19a-79-5a(2)(e)</u>	<u>8:1</u>
<u>#38 - observed 1 individual care plan not signed by staff.</u>	<u>4:1</u>
<u>19a-79-7a(h)(3) - observed 1 piece of white #89 feces in diaper - falling down.</u>	<u>9:2</u>
<u>19a-79-9a (b)(3)(B) - observed 4 medication #102</u>	<u>17:2</u>
<u>Administration forms incomplete (2 children)</u>	<u>20:1</u>
<u>discussed: measured room to convert to an under 3's room:</u>	<u>20:2</u>
<u>23.8 x 33 = 785.4 ÷ 35 = 22.4</u>	<u>11:1</u>
<u>needed for approval: fire marshal approval, local health approval, changing table, diapering/handwash procedure posted, room set up for under 3's OEC visit & approval. room may not be used prior to receiving OEC approval.</u>	<u>15:2</u>
	<u>14:2</u>

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: 6/14/23

Signature: [Signature]
(OEC Representative)
Print Name: Kristi Morgan
Signature: [Signature]
(Person in Charge)
Print Name: Delia Wrablewski