



FAMILY CHILD CARE HOME SUPPLEMENTAL INSPECTION

| | | | | | | |
|------------------------------|---|----------------------------------|--------------------------|----------------------|----------------------------|------------|
| Provider | JOSETTE COLAS-LESPERANCE | | License Number | DCFH.57517 | Date of Inspection | 03/12/2024 |
| | | | Expiration Date | 7/31/2025 | Time of Inspection | 09:54 AM |
| Address | 20 NORTH ST APT 7/2 STAMFORD CT 06902-2363 | | Telephone | (203) 252-6296 | Regular Capacity | 6 |
| | | | Days and Hours | M-F 8:00 am- 5:30 pm | School Age Capacity | 0 |
| # Children Present | 0 | # Under 18 months present | 0 | | Summer Care | Open |
| Purpose of Inspection | Follow up on Open Inspection from 9/29/2023 CAP | | Name of Inspector | Candy Vargas | | |
| Provider's Email | JLESPERANCE09@GMAIL.COM | | Inspector's Email | candy.vargas@ct.gov | | |

CONSENT TO INSPECT: I agree to allow the Commissioner or an authorized representative to have access to and inspect the facility and child care records during home inspections as required by Regulations Section 19a-87b-5(h).

Signature of Provider/Applicant/Substitute/Emergency Caregiver

Violations

| Statute and/or Regulation | Description | Comments |
|---------------------------|-------------------|---|
| [-] | 000 No Violations | No violations were cited during this inspection |

| | | |
|--|--|--|
| | | |
|--|--|--|

| | | |
|-------------------------------------|--|--|
| Other Findings-In Compliance | | |
|-------------------------------------|--|--|

| Statute and/or Regulation | Description | Comments |
|----------------------------------|---------------------------|-----------------|
| [19a-87b-6(c)] | 014-First Aid Certificate | |
| [19a-87b-6(c)] | 015-CPR Certificate | |

| | | |
|--|--|--|
| | | |
|--|--|--|



| | |
|-------------------|---|
| YES/NO: No | WERE VIOLATIONS CITED DURING THIS VISIT? |
|-------------------|---|

Discussions:

There are no children present, provider has no children enrolled in the program. Provider is working outside the home as a CNA in the evenings.
 Provider was informed that her Medical statement needs to be updated.
 Both completed CAPs were retrieved at the time of inspection.

Comments:

NOTE: Items left blank on this form were not monitored during this visit.
 Only the regulations marked as compliant or non-compliant were monitored or discussed.
APPLICANTS: You MAY NOT OPERATE until all requirements have been met and a license has been issued by the Agency.

| | | | |
|---|---------------------------------------|---|--|
|  (Signature of OEC Representative) | (Signature of OEC Representative) | DATE CORRECTIONS DUE BY: |  (Signature of Person in Charge) |
| Candy Vargas (Printed Name) | (Printed Name) | | JOSETTE COLAS-LESPERANCE (Printed Name) |