

LICENSING CORRECTIVE ACTION PLAN (CAP)

NAME OF PROVIDER/OPERATOR: SPHERE Summer Program at Watkinson LICENSE #: 00660
 LOCATION ADDRESS: 180 Bloomfield Ave, Hartford, CT 06105 TOWN: Hartford INSPECTION REPORT DATE: 7/9/2024

CAPs submitted that do not conform to the instructions provided on the back will not be accepted. Read the instructions carefully before completing this form. In accordance with this agency's policy, **your CAP will be posted online** and made accessible to parents and others seeking information pertaining to your child care program.

Inspection Report Item # or Regulation	Corrective Action Taken	Exact Date Corrected	Check if Accepted (OEC Use Only)
	NOTE: Your response should include a clear concise explanation of the changes the program has made to correct the violation to ensure compliance.		
24b	Background checks were immediately initiated by the HR office on 7/9/2024. Results for both employees are in progress and, as of 7/16/2024, are listed on the BCIS roster as "pending."	7/9/2024	✓
76	Camp on-call APRN met with and trained on-site first aid director in "oral, topical, and inahlant medication" and "injectable medicatrions by a premeasured commercially prepared auto-injector." Camp APRN completed and signed Written Approval for Administration of Medication Training for Youth Camps form on 7/10/2024.	7/10/2024	✓

Based on the inspection report, the licensee was cited for failure to comply with the regulations listed above. I hereby declare that the licensee has complied with the regulation(s) in the above manner. I understand the Agency reserves the right to re-inspect the above program to verify compliance with the regulations and to request a meeting with the licensee when necessary to review patterns of non-compliance. Understanding the penalties for false statements, I attest that the information I submit on this form is true.

If the violations of child care regulations referenced in the Report(s) related to this Corrective Action Plan reoccur in the future, the violations may no longer be considered resolved by this Corrective Action Plan and the Agency may bring disciplinary action based upon the violations identified in the Report(s) related to this Corrective Action Plan.

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



By checking this box, and typing my name below, I am electronically signing my CAP.

Signed: Courtney Massenberg 7/16/2024
 (Provider/Operator) (Date)

RETURN TO: _____
 Connecticut Office of Early Childhood
 450 Columbus Blvd, Suite 302
 Hartford, CT 06103 Fax: 860-326-0552

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Signed: _____
(Provider/Operator) (Date)

Printed Name: _____