

**FAMILY CHILD CARE HOME INSPECTION REPORT**

| INSPECTION DATE/TIME/DURATION:<br><b>3/7/2024 9:00 AM</b>                            |                                                            | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">INSPECTION TYPE</th> </tr> <tr><td><input type="checkbox"/></td><td>Initial Application</td></tr> <tr><td><input type="checkbox"/></td><td>Conversion</td></tr> <tr><td><input type="checkbox"/></td><td>Mandatory Review</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Full</td></tr> <tr><td><input type="checkbox"/></td><td>Complaint Investigation</td></tr> <tr><td><input type="checkbox"/></td><td>Monitoring</td></tr> <tr><td><input type="checkbox"/></td><td>Other</td></tr> <tr> <td><input type="checkbox"/></td> <td>Follow Up</td> </tr> </table> |           | INSPECTION TYPE                                                     |  | <input type="checkbox"/>    | Initial Application | <input type="checkbox"/> | Conversion | <input type="checkbox"/> | Mandatory Review | <input checked="" type="checkbox"/> | Full | <input type="checkbox"/> | Complaint Investigation | <input type="checkbox"/> | Monitoring | <input type="checkbox"/> | Other | <input type="checkbox"/> | Follow Up | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>AGES</th> <th>Registered for</th> <th># Enrolled</th> <th># Present</th> <th>Resident Children</th> </tr> <tr> <td>0-23 Months</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>2's</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>3's</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>4's</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>5's (pre-school)</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>5-12 (school-age)</td> <td><input checked="" type="radio"/> Y <input type="radio"/> N</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td><b>TOTAL</b></td> <td></td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Overnight</td> <td></td> <td>0</td> <td>0</td> <td>XXXXXX</td> </tr> <tr> <td>Head Start</td> <td>XXXXXXXX</td> <td>0</td> <td>XXXXXX</td> <td>XXXXXX</td> </tr> </table> |  |  | AGES | Registered for | # Enrolled | # Present | Resident Children | 0-23 Months | 1 | 0 | 0 | 0 | 2's | <input checked="" type="radio"/> Y <input type="radio"/> N | 0 | 0 | 0 | 3's | <input checked="" type="radio"/> Y <input type="radio"/> N | 0 | 0 | 0 | 4's | <input checked="" type="radio"/> Y <input type="radio"/> N | 0 | 0 | 0 | 5's (pre-school) | <input checked="" type="radio"/> Y <input type="radio"/> N | 0 | 0 | 0 | 5-12 (school-age) | <input checked="" type="radio"/> Y <input type="radio"/> N | 0 | 0 | 0 | <b>TOTAL</b> |  | 0 | 0 | 0 | Overnight |  | 0 | 0 | XXXXXX | Head Start | XXXXXXXX | 0 | XXXXXX | XXXXXX |
|--------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------------------------------------------------------|--|-----------------------------|---------------------|--------------------------|------------|--------------------------|------------------|-------------------------------------|------|--------------------------|-------------------------|--------------------------|------------|--------------------------|-------|--------------------------|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------|----------------|------------|-----------|-------------------|-------------|---|---|---|---|-----|------------------------------------------------------------|---|---|---|-----|------------------------------------------------------------|---|---|---|-----|------------------------------------------------------------|---|---|---|------------------|------------------------------------------------------------|---|---|---|-------------------|------------------------------------------------------------|---|---|---|--------------|--|---|---|---|-----------|--|---|---|--------|------------|----------|---|--------|--------|
| INSPECTION TYPE                                                                      |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                             | Initial Application                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                             | Conversion                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                             | Mandatory Review                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input checked="" type="checkbox"/>                                                  | Full                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                             | Complaint Investigation                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                             | Monitoring                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                             | Other                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <input type="checkbox"/>                                                             | Follow Up                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| AGES                                                                                 | Registered for                                             | # Enrolled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | # Present | Resident Children                                                   |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 0-23 Months                                                                          | 1                                                          | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0         | 0                                                                   |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 2's                                                                                  | <input checked="" type="radio"/> Y <input type="radio"/> N | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0         | 0                                                                   |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 3's                                                                                  | <input checked="" type="radio"/> Y <input type="radio"/> N | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0         | 0                                                                   |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 4's                                                                                  | <input checked="" type="radio"/> Y <input type="radio"/> N | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0         | 0                                                                   |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 5's (pre-school)                                                                     | <input checked="" type="radio"/> Y <input type="radio"/> N | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0         | 0                                                                   |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| 5-12 (school-age)                                                                    | <input checked="" type="radio"/> Y <input type="radio"/> N | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0         | 0                                                                   |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| <b>TOTAL</b>                                                                         |                                                            | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0         | 0                                                                   |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| Overnight                                                                            |                                                            | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0         | XXXXXX                                                              |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| Head Start                                                                           | XXXXXXXX                                                   | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | XXXXXX    | XXXXXX                                                              |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| PROVIDER ID:<br><b>216783</b>                                                        |                                                            | REGION:<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |           | Fatality:<br><b>0</b>                                               |  | Serious Injury:<br><b>0</b> |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| REGISTRATION #:<br><b>156331</b>                                                     |                                                            | EXCELS LEVEL:<br><b>1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           | COMPLAINT #:                                                        |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| JURISDICTION:                                                                        |                                                            | ACCREDITED: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           | ACCREDITED BY:                                                      |  | EXP DATE:                   |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
|                                                                                      |                                                            | HOMEOWNER'S INSURANCE COVERAGE: <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Y <input type="checkbox"/> N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |           |                                                                     |  | EXP DATE:                   |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| BUSINESS NAME:                                                                       |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| PROVIDER NAME:<br><b>Latisha Laury</b>                                               |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| CO-PROVIDER:                                                                         |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| ADDRESS:<br><b>1509 North Potomac Street</b> <b>Baltimore</b> <b>MD</b> <b>21213</b> |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| PERSONS INTERVIEWED:<br><b>Latisha Laury</b>                                         |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| TITLE(S):<br><b>Provider</b>                                                         |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                     |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
| TELEPHONE:<br><b>(410) 485-2690</b>                                                  |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           | E-MAIL:<br><b>latisha_edmonds@yahoo.com</b>                         |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |
|                                                                                      |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           | <input checked="" type="radio"/> Verified <input type="radio"/> N/A |  |                             |                     |                          |            |                          |                  |                                     |      |                          |                         |                          |            |                          |       |                          |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |      |                |            |           |                   |             |   |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |     |                                                            |   |   |   |                  |                                                            |   |   |   |                   |                                                            |   |   |   |              |  |   |   |   |           |  |   |   |        |            |          |   |        |        |



**PART 1 - MANDATORY REVIEW ITEMS**

INSTRUCTIONS: (1) Review each regulation that applies to the inspection being conducted.  
 (2) The compliance status of an item listed under Part 2 may be recorded when deemed necessary.  
 (3) Initial/Resumption/Conversion/Full Inspection - Complete both Part 1 and Part 2.

**C = In Compliance, D = Discussed, N = Not in Compliance, X = Not Inspected, NA = Not Applicable**

|                    |                                     |                 |                                                    |
|--------------------|-------------------------------------|-----------------|----------------------------------------------------|
| <u>C</u> .02.01D   | Certificate Conspicuously Displayed | <u>C</u> .06.02 | Training Requirements                              |
| <u>C</u> .03.04A   | Emergency Forms                     | <u>C</u> .07.01 | Prohibition of Abuse, Neglect, Injurious Treatment |
| <u>C</u> .03.05C-E | Notification of Changes             | <u>C</u> .07.02 | Abuse and Neglect Reporting                        |
| <u>C</u> .04.03    | Child Capacity                      | <u>C</u> .07.04 | Child Discipline                                   |
| <u>C</u> .05.03    | Cleanliness and Sanitation          | <u>C</u> .07.07 | Child Security                                     |
| <u>C</u> .05.04    | Rooms Used for Care                 | <u>C</u> .08.01 | General Child Supervision                          |
| <u>C</u> .05.05    | Outdoor Activity Area               | <u>C</u> .10.02 | Potentially Hazardous Items                        |
| <u>C</u> .05.06    | Rest Furnishings                    | <u>C</u> .10.06 | Rest Time Safety                                   |

**PART 2 – GENERAL COMPLIANCE REVIEW**

INSTRUCTIONS: The compliance status of an item listed under Part 1 is excepted (exc.) from recording under Part 2.

**C = In Compliance, D = Discussed, N = Not in Compliance, X = Not Inspected, NA = Not Applicable**

**CHAPTER 02 REGISTRATION APPLICATION AND MAINTENANCE**

|               |                         |
|---------------|-------------------------|
| <u>N</u> .03B | Continuing Registration |
| <u>C</u> .04B | Conditional Status      |

**CHAPTER 03 MANAGEMENT & ADMINISTRATION**

|              |               |
|--------------|---------------|
| <u>C</u> .01 | Advertisement |
|--------------|---------------|

**CHAPTER 03 MANAGEMENT & ADMINISTRATION, CON'T**

|              |                          |
|--------------|--------------------------|
| <u>C</u> .02 | Admission to Care        |
| <u>C</u> .03 | Program Records          |
| <u>C</u> .04 | Child Records [exc. A]   |
| <u>C</u> .05 | Notifications [exc. C-E] |
| <u>C</u> .06 | Variances                |



**PART 2 – GENERAL COMPLIANCE REVIEW, CON'T****INSTRUCTIONS:** The compliance status of an item listed under Part 1 is excepted (exc.) from recording under Part 2.**C = In Compliance, D = Discussed, N = Not in Compliance, X = Not Inspected, NA = Not Applicable****CHAPTER 04 OPERATIONAL REQUIREMENTS**C.01 Hours of CareC.02 Age Group Enrollment**CHAPTER 05 HOME ENVIRONMENT & EQUIPMENT**C.01 Suitability of the HomeC.02 Lead-Safe Environment**CHAPTER 06 PROVIDER REQUIREMENTS**C.03 Provider SubstituteC.04 Additional AdultC.05 Volunteers**CHAPTER 07 CHILD PROTECTION**C.03 Applicability to ResidentsC.05 Parental AccessC.06 Authorized Release**CHAPTER 08 CHILD SUPERVISION**C.02 Off-Site SupervisionC.03 Water Activity SupervisionC.04 Overnight Care Supervision**CHAPTER 09 PROGRAM REQUIREMENTS**C.01 ActivitiesC.02 Materials/EquipmentC.03 Rest Periods**CHAPTER 10 SAFETY**C.01 Emergency SafetyC.03 Outdoor SafetyC.04 Water SafetyC.05 Transportation Safety**CHAPTER 11 HEALTH**C.01 Child Comfort/WelfareC.02 Exclusion for Acute IllnessC.03 Infectious/Communicable DiseasesC.04 Medication Administration/StorageC.05 SmokingC.06 Consumption of Alcohol/Drugs



**PART 2 – GENERAL COMPLIANCE REVIEW, CON'T**

**INSTRUCTIONS:** The compliance status of an item listed under Part 1 is excepted (exc.) from recording under Part 2.

**C = In Compliance, D = Discussed, N = Not in Compliance, X = Not Inspected, NA = Not Applicable**

**CHAPTER 12 NUTRITION**

C.01 Nutrition/Food Served  
C.02 Food Storage/Cleanliness

**CHAPTER 13 INSPECTIONS, COMPLAINTS & ENFORCEMENTS**

C.01 Inspections  
C.06 Emergency Suspension



\_\_\_\_\_  
Signature of Provider



\_\_\_\_\_  
Signature of Agency Representative  
Shonette Wilson

**3/07/2024**

\_\_\_\_\_  
Date