

FACILITY VISIT

Facility Name: TCSD Cubs

Date: 10/27/2022

Time: 12:45

Provider: _____

Certificate #: 016970

Phone: 307-734-4408

Address: 245 E Deloney St

City: Jackson

Facility Type: ___ FCCH ___ FCCC X CCC

Comments/TA Provided:

Unannounced visit. Attendance record verified with children present in each classroom. INFANT BLDG: (1) staff, (2) children present. Ages: (1) infant, (1) age 1. Children are finishing lunch. TODDLER BLDG: (2) staff, (9) children present. Ages: (1) age 1, (7) age 2, (1) age 3. Children are participating in free play. Staff:child ratio and supervision checked. Staff records checked prior to visit. A current CCL-205 was previously provided to Licenser. (4) staff have been hired since last visit. Staff records verified. We discussed all upcoming expiring items. (1) TA provided for variance that is needed for visiting therapists. Licenser provided form at visit. (1) TA provided for TB assessment for (1) staff not on file at facility. Facility hours were updated.

Childcare Licenser:



Date: 10/27/2022

Director/Provider:



Date: 10/27/2022