

FACILITY VISIT

Facility Name: TCSD Cubs

Date: 03/06/2020

Time: 02:00

Provider: _____

Certificate #: 016970

Phone: 307-734-4408

Address: 245 E Deloney St

City: Jackson

Facility Type: ☐ FCCH ☐ FCCC ☒ CCC

Comments/TA Provided:

Delivered CCL-301 Notice of Allegations for investigation of reported concern. Upon arrival in the infant building there were 2 staff with 5 infants and no staff with the 3 one year olds. One infant was awake in the infant room and 2 of the one year olds were awake in that room. In the 2 and 3 year old building there was 1 staff with 12 children. There is currently no staff attendance for hours worked. They work off of a schedule that does not reflect when some one leaves the premises.

Director/Provider: _____

Date: _____

Childcare Licensur: _____

Date: _____