

**ALABAMA DEPARTMENT OF HUMAN RESOURCES
CHILD CARE PERFORMANCE STANDARDS DEFICIENCY REPORT**

SECTION A- IDENTIFYING INFORMATION

Facility Name: SPROUT EARLY LEARNING CENTER	Type of Facility : Center <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> OST <input type="checkbox"/> Night <input type="checkbox"/> Family <input type="checkbox"/> University <input type="checkbox"/> Group <input type="checkbox"/>	Date of Visit: 06/13/2025
Facility Address: 5327 ALABAMA HIGHWAY 93, BANKS, AL 36005, Pike	Licensee: TROY RESILIENCE PROJECT	Telephone #: (334) 905-0204
Ages: 0 Years to 5 Years	Director (if applicable): ELLEN Nichols DOSS	Capacity: 73 / NA Day Night

SECTION B - DEFICIENCY INFORMATION

Performance Standard Deficiency <i>HAZARDS MUST BE CORRECTED IMMEDIATELY*</i>	Date Corrected by Licensee
<p>Deficiency Summary</p> <p>Failed - Medical, Staff Checklist Comments: no Medical</p> <p>Failed - Verification of Education, Staff Checklist Comments: Miss education</p> <p>Failed - Health and Safety Training, Staff Checklist Comments: Missing Health and safety training</p> <p>Failed - Verification of Education, Staff Checklist Comments: Verification of educatio</p> <p>Failed - Interstate CA/N if applicable (within 5 years), Staff Checklist Comments: Needs interstate CAN</p> <p>Failed - Health and Safety Training, Staff Checklist Comments: Missing Health and Safety training</p> <p>Failed - Medical, Staff Checklist Comments: Missing medical</p> <p>Failed - TB Test Date and Results, Staff Checklist Comments: Missing tb</p> <p>Failed - Health and Safety Training, Staff Checklist Comments: Needs Health and safety</p> <p>Failed - Verification of Education, Staff Checklist Comments: Missing education</p> <p>Failed - Health and Safety Training, Staff Checklist Comments: Health and safety training</p>	

INSTRUCTIONS TO LICENSEE: Column 2, Date Corrected by Licensee, is to be completed by the facility representative after each deficiency is corrected. The facility representative must put the date of correction and his/her initials in Column 2. This form must be returned to the Department of Human Resources on or before _____, as verification that deficiencies have been corrected.

NOTICE: Any misleading or any false statements or reports made to the Department and/or failure to correct the listed deficiencies can be the basis for adverse action. None of these requirements are to be interpreted to allow anyone to operate in violation of Performance Standards. A facility licensed by the Department must always meet Performance Standards applicable to that facility. It is the responsibility of the licensee to operate in compliance with Performance Standards.

Signature of Facility Representative

Date

Karen Jackson-Moulton

Signature of DHR Licensing Representative

Date

COPIES TO: _____