**ALABAMA DEPARTMENT OF HUMAN RESOURCES**
**CHILD CARE HEALTH & SAFETY GUIDELINES DEFICIENCY REPORT**

## SECTION A- IDENTIFYING INFORMATION

| Facility Name: | Type of Facility : | Date of Visit: |
|---|---|---|
| ALECIA L MCCANTS | Day [X]<br>Night [ ]<br>Both [ ] | 10/29/2025 |
| **Facility Address:**<br>1000 Hillcrest Rd., 340-B Mobile, AL 36695, Mobile | | **Telephone #:**<br>(251) 599-7621 |
| **Ages:**<br>5 Days to 12 Days | **Staff in Charge** *(if applicable)*:<br>Alecia McCants | **Capacity:**<br>36 , NA<br>Day Night |

## SECTION B - DEFICIENCY INFORMATION

| Health & Safety Guidelines Deficiency | Date Corrected |
|---|---|
| **Deficiency Summary** | |
| Failed - Outdoor area adjoins or is safely accessible, Inspection Form<br>Comments: The outdoor area was not safety accessible to the inside. | 10/29/2025 |
| Failed - Ongoing Training, Staff Checklist<br>Comments: Staff is missing transportation training. | 11/3/2025 |
| Failed - Ongoing Training, Staff Checklist<br>Comments: Staff is missing transportation training. | 11/3/2025 |
| Failed - Medical, Staff Checklist<br>Comments: Staff medical report is not date. | 11/3/2025 |

**INSTRUCTIONS TO PERSON IN CHARGE: Column 2, Date Corrected 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 ______11/12/2025__________, 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 Health & Safety Guidelines. A facility approved by the Department must meet Health & Safety Guidelines applicable to that facility at all times. It is the responsibility of the facility to operate in compliance with Health & Safety Guidelines.**

Alecia L McCants

***Signature of Facility Representative***

10/29/25
**Date**

TAVIA WOODS

**Signature of DHR Representative**

10/29/2025

**Date**

COPIES TO: ________________

**ALABAMA DEPARTMENT OF HUMAN RESOURCES**

**CHILD CARE HEALTH & SAFETY GUIDELINES DEFICIENCY REPORT**

**Facility Name:** ALECIA L MCCANTS **Date of Visit:** 10/29/2025

**SECTION B - DEFICIENCY INFORMATION (Continued)**

| Health & Safety Guidelines Deficiency | Date Corrected |
|---|---|
| **Deficiency Summary** | |
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| Failed - Medical, Staff Checklist<br>Comments: Staff medical report is not date. | 11/3/2025 |

**INSTRUCTIONS TO FACILITY: Column 2, Date Corrected 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 ________11/12/2025________, 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 Health & Safety Guidelines. A facility approved by the Department must meet Health & Safety Guidelines applicable to that facility at all times. It is the responsibility of the facility to operate in compliance with the Health & Safety Guidelines**

______________________________

Alecia L McCarth

**Signature of Facility Representative** 10/29/25 **Date**

TAVIA WOODS 10/29/2025

______________________________

**Signature of DHR Representative** **Date**

COPIES TO:

**PROCEDURESDEFICIENCY REPORT**

*This form is to be used to record deficiencies observed by DHR Representative or admitted to by the facility's staff, during visits to facilities. The form may be used in conjunction with an evaluation form or at any time a deficiency is noted. The form should be completed and reviewed with the facility representative at the end of the visit. A copy of the form should be left at the facility or mailed to the facility after the visit. The original must be placed in the Department's file. The form is to be handwritten or printed so that it is readable. All sections are to be completed by the DHR representative unless otherwise noted. Additional pages may be used if needed. Note number of pages, such as page 1 of 3.*

**SECTION AIDENTIFYING INFORMATION**

FACILITY NAMERecord name of the facility.
TYPE OF FACILITYCheck all that apply.
DATE OF VISITDate of completion of deficiency report.
FACILITY ADDRESSStreet address of the facility, not P. O. Box or mailing address.
TELEPHONE #Telephone number of the facility, including area code.
STAFF IN CHARGEName of person in charge during visit.
AGESAge range of children.
CAPACITYNumber of children according to capacity requirements.

**SECTION BDEFICIENCY INFORMATION**

Column 1-HEALTH & SAFETY GUIDELINES DEFICIENCY-Describe the deficiency observed; for example: childstaff ratio in the three-year-old group, children's records incomplete.
Column 2-DATE CORRECTED BY FACILITY REPRESENTATIVE should record the date each deficiency is corrected and his/her initials in Column 2. A copy of the deficiency report with corrections noted must be sent to DHR on or before the date indicated. If a follow-up visit is conducted by the DHR representative and deficiencies have not been corrected, or if