

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

SECTION A- IDENTIFYING INFORMATION

Facility Name: TEDDY BEARS CHILD CARE	Type of Facility : Center [X] Day [X] OST [] Night [X] Family [] University [] Group []	Date of Visit: 9/15/2026
Facility Address: 3763 DAUPHIN ISLAND PKWY., MOBILE, AL 36605, Mobile	Licensee: ARNETTA CRAIG	Telephone #: (251) 478-1441
Ages: 6 Weeks to 17 Years/6 Weeks to 17 Weeks	Director (if applicable):	Capacity: 56 / 56 Day Night

SECTION B - DEFICIENCY INFORMATION

<u>Performance Standard Deficiency</u> HAZARDS MUST BE CORRECTED IMMEDIATELY*	Date Corrected by Licensee
Deficiency Summary	
Children files have been checked. Corrected deficiencies verified through ARISE.	
Failed - TB Test Date and Results, Staff Checklist Comments: Missing test date.	9/22/2026
Failed - TB Test Date and Results, Staff Checklist Comments: Missing date	9/22/2026
Failed - Ongoing Training, Staff Checklist Comments: Missing	9/22/2026
Failed - Verification of Education, Staff Checklist Comments: Missing	9/22/2026

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.

Arnetta Craig

Sept. 22, 2026

Signature of Facility Representative

Date

LaDanika York

09/22/26

***Signature of DHR Licensing
Representative***

Date

COPIES TO: _____ Facility _____