



Andy Beshear
GOVERNOR

**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

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Inspection Report

Provider Name: Olive Hill Head Start	Provider Information	License No: L352263
Provider Address: 21039 W. Us Hwy 60, Olive Hill, KY, 41164	Provider Type: LICENSED TYPE I	Capacity: 80
Owner(s): Northeast Kentucky Community Action Agency, Inc.		Director(s): Hammond, Alyce Faye

Inspection Type: Investigation	Inspection Information	Inspection No: 190864
Visit Start Date: 05/27/2015 9:00 AM	Visit End Date: 05/28/2015 10:30 AM	
	No. of Children Present: 70	

Inspection Report	
Supervision	
5 - Children Supervised	Not In Compliance
<p>922 KAR 2:120. Section 2. Child Care Services.</p> <p>(3)(a) Each center shall maintain a child-care program that assures each child will be:</p> <p>1. Provided with adequate supervision at all times by a qualified staff person who:</p> <p>a. Ensures the child is within scope of vision and range of voice; or</p> <p>b. For a school-age child, within scope of vision or range of voice;</p> <p>Findings:</p> <p>General: Based on Interview, it was determined that a four (4) year old child was left alone in the boys bathroom. The supervisor stated that the child would not have been alone for any more than three minutes.</p>	
Staffing Requirements	
40 - Ratios and Group Size	In Compliance

922 KAR 2:120. Section 2. Child Care Services.

(2) Minimum staff-to-child ratios and group size for an operating child-care center shall be maintained as follows:

Age of Children Ratio Maximum Group Size*

Infant

1 staff for 5 children 10

Toddler

1 staff for 6 children 12

Preschool-age 2 to 3 years

1 staff for 10 children 20

Preschool-age 3 to 4 years

1 staff for 12 children 24

Preschool-age 4 to 5 years

1 staff for 14 children 28

School-age 5 to 7 years

1 staff for 15 children 30

School-age 7 and older

1 staff for 25 children

(for before and after school) 30

1 staff for 20 children

(full day of care) 30

***Maximum Group Size shall be applicable only to Type I child-care centers.**

Signature of
Provider/Representative

Title

Date