



Child Care Licensing Unit

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I. Program Information

STATEMENT OF FINDINGS

ISSUE DATE : 7/31/2026

VISIT DATE : 7/29/2026

VISIT TYPE : Licensed Complaint

CORRECTIVE ACTION PLAN DUE DATE : 8/21/2026

Name of the program : The Chase Home For Children

Program address : 698 Middle Road Portsmouth New Hampshire 03801

License No. : CCRB-01061

Licensing Coordinator : Christine Conlon

As a result of a visit conducted in accordance with RSA 170-E, the department finds that the program was in compliance with statute/rule.

II. Founded, Problem Resolved

Regulation number: He-C 4001.15(c)(1)

Authorized staff shall know and understand the program's written policies and procedures regarding the administration, documentation, control, and safety of medication.

Observation: The program self reported that the health advocate responsible for medication for the residents, did not comply with the policies of the program in regards to resident medication. The licensing coordinator's review of the program's Internal Incident Review form and the Critical Incident Report revealed that this resident had previously been prescribed 150mg of Trazadone, where 1/2 tablet equaling 75mg was to be taken nightly, and the health advocate was giving the resident 150mg nightly. The Health Advocate stated they had misread the prescriber's information and decided to continue giving 150mg nightly until the next medication check. The program verified that this decision was not made per policy which is to obtain DCYF approval. The program sent the resident to the Emergency Room to have the medications adjusted and have them evaluated for the increased dosage, terminated the health advocate and has also started an internal medication audit to confirm all the prescriptions for residents are accurate.

Regulation number: He-C 4001.15(w)

No person other than a licensed practitioner shall make changes to the written order of a licensed practitioner regarding prescribed medication.

Observation: The program self reported that the health advocate responsible for medication for the residents had misread the prescriber's information when requesting a refill. The prescription was 150mg tablet and 1/2 of that tablet equaling 75mg to be given nightly and the refill requested was 150mg nightly. Upon realizing the mistake, the health advocate continued to give the increased dosage until the next medication check. The program confirmed that the health advocate is not a licensed practitioner, therefore not allowed to make these changes to medication themselves. The program sent the resident to the Emergency Room to have the medications adjusted and have them evaluated for the increased dosage, terminated the health advocate and has also started an internal medication audit to confirm all the prescriptions for residents are accurate.