



Child Care Licensing Unit

129 PLEASANT STREET CONCORD, N.H. 03301-3857

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I. Program Information

STATEMENT OF FINDINGS

ISSUE DATE : 3/31/2025

VISIT DATE : 3/10/2025

VISIT TYPE : Licensed Complaint

CORRECTIVE ACTION PLAN DUE DATE :

Name of the program : Nashua Children's Home

Program address : 125 Amherst Street Nashua New Hampshire 03064

License No. : CCRB-01069

Licensing Coordinator : Tasha Berube

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.4001.20.(a)

He-C.4001.20.(a) : Program staff shall provide care and supervision at all times to ensure that residents are safe and that their needs are met according to their developmental level, age, emotional or behavioral needs, and in accordance with their treatment plan.

Observation: The complainant reported that on one Unit on February 26, 2025, at 11:25 p.m., Resident A asked Staff A if they could fill up their water in the kitchen and Staff A agreed. When Resident A left the kitchen, they saw that Staff A was not looking and snuck into Resident B's bedroom where they remained until 3:12 a.m. The complainant also reported that Staff A did not ensure that Resident A returned to their bedroom after filling their water in the kitchen. Staff A stated they were the asleep overnight residential counselor on this Unit on February 26, 2025, and that they did observe Resident A leave their bedroom to get water in the kitchen and then return to their bedroom. Staff A stated they did not see Resident A again until 5:00 a.m. the following morning. Additionally, Staff A stated they are not required to stay awake during their overnight shift, and they are not required to do bed checks throughout the night. Staff B, who was working as an awake overnight supervisor, and Staff C, who was working as an awake overnight residential counselor, stated that they did not work on this specific Unit on February 26, 2025, however, they were responsible for monitoring the live video feeds on the units to assure the residents were in their bedrooms. Staff B and Staff C also stated that they did not

observe Resident A go into Resident B's bedroom on the live video feed. A review of the video footage from the living room and hallway cameras of this specific Unit revealed that on February 26, 2025, at 11:25 p.m., Resident A can be seen leaving their bedroom and going into the kitchen. Staff A did not appear to see Resident A leave their bedroom. A few seconds later, Resident A checked to see if Staff A was looking in their direction and when they observed Staff A was not looking, they went into Resident B's bedroom. At 3:12 a.m., Resident A is seen leaving Resident B's bedroom, and as they passed the kitchen, Staff A appears to notice Resident A returning to their bedroom. Staff D stated that, as a result of this incident, they began staffing this Unit with an awake overnight residential staff whose responsibilities include conducting regular bed checks throughout the night.