



Child Care Licensing Unit

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I. Program Information

STATEMENT OF FINDINGS

ISSUE DATE : 2/11/2025

VISIT DATE : 1/9/2025

VISIT TYPE : Licensed Complaint

CORRECTIVE ACTION PLAN DUE DATE : 3/4/2025

Name of the program : MPA at Pike: The Hall Farm and Blake House

Program address : 1977 and 2056 Mount Moosilauke Highway Pike New Hampshire 03780

License No. : CCRB-05146

Licensing Coordinator : Heather Dombroski

In accordance with RSA 170-E, the department finds non-compliance with the following statutes and/or rules:

II. Non-Compliance List

Regulation number : He-C.4001.19.(a)(1)

He-C.4001.19.(a)(1) : Program staff shall relate with residents in a professional, respectful manner.

Observation : The program self-reported that during an internal inquiry, Staff A stated they gave Resident B gifts of food, toys, and a smart watch. Staff A stated to department staff that they purchased ice cream, a toy truck and a smart watch for Resident B, all of which were outside of their professional duties as a staff member of the program. Department staff reviewed video for the overnight shifts for December 22-23, 2024, December 23-24, 2024, Dec 30-31, 2024, Dec 31, 2024 – January 1, 2025, and January 1-2, 2025, and noted that Staff A brought Resident A food on at least two occasions during the overnight shifts and made their personal cell phone available to Resident B.

Corrective Action Plan : Based on violation of state regulation..... faculty member was put on admin leave until completion of investigation and subsequently terminated for the above dereliction of assigned duties and the concerns related to boundary violation. Following the event, there was a refresher training on boundaries specific to Handbook section 9.1 Professional Boundaries There was an implementation of an updated bed check protocol specifically all bed checks will be uploaded into our EMS Extended Reach with time stamping capacity as opposed to utilizing a paper based system. There will be ongoing debriefing with all Pike faculty around boundaries. Training using the ARC

trauma model of care will also continued to be provided to support sending clear messaging to all faculty around the impact of these behaviors on children. This training is also part of every faculty onboarding. Pike admin continues to reinforce the concept of "see something say something" to support proactive assessment of any future inappropriate relationships and to continue to support a trauma informed and safe culture on campus

Completion Date : 1/2/2025

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 program self-reported that on January 1, 2025, Resident A stated they could not find Staff A for almost an hour during the overnight shift. Staff B stated that they reviewed video of that night and found Staff A entered Resident B's room approximately 7 times and closed the door, and that the longest Staff A was in the resident's room was for 58 minutes. Staff B reviewed additional video and reported that Staff A had entered Resident B's room on multiple nights for long periods of time. Staff B also stated that Staff A did not complete any of the required room checks during the dates reviewed. Staff A confirmed to Department staff they did not complete the required bed checks for other residents while they were in Resident B's room. Staff A also stated they knew they were non-compliant with the program's policy for awake overnight supervision. The job description for an awake overnight youth counselor describes the requirement to conduct fifteen-minute bed-checks. The policy on supervision of children, in the section on overnight supervision, requires awake overnight faculty to check each student every 15 minutes and initial a log of these 15-minute checks, and to observe the student's hair, skin and/or movement to be certain the student is in their bed, safe, and sleeping. Department staff reviewed video for the overnight shifts for December 22-23, 2024, December 23-24, 2024, Dec 30-31, 2024, Dec 31, 2024 – January 1, 2025, and January 1-2, 2025 which confirmed Staff A did not conduct any bed checks on the second floor. Staff A did not provide care and supervision at all times for all residents on the second floor during the overnight shift to ensure that the residents were safe and that their needs were being met, including on January 1, 2025, when Resident A could not locate Staff A for almost one hour.

Corrective Action Plan : Based on violation of state regulation..... faculty member was put on admin leave until completion of investigation and subsequently terminated for the above dereliction of assigned duties. Moving forward Executive Director will review overnight video based footage on a weekly basis to observe and assess and identify potential dereliction of duties per regulation. There was an implementation of an updated bed check protocol specifically all bed checks will be uploaded into our EMS Extended Reach with time stamping capacity as opposed to utilizing a paper based system. All Job Descriptions for overnight faculty will be re-reviewed and signed off on ensuring that there are no questions in regards to the job expectations and state regulations Feedback from the weekly video footage will be provided to all overnight faculty in supervision with the goal of assessing and performance and any potential dereliction of duty

Completion Date : 1/2/2025