



Child Care Licensing Unit

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I. Program Information

STATEMENT OF FINDINGS

ISSUE DATE : 4/22/2025

VISIT DATE : 3/11/2025

VISIT TYPE : Licensed Complaint

CORRECTIVE ACTION PLAN DUE DATE : 5/13/2025

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 : Staff A stated that during a critical incident involving Resident A, they yelled at Staff B and Resident B to "get the [expletive] out!" Resident B reported they had heard Staff A yell before but "nothing like this," in reference to the incident with Resident A. Resident A reported that Staff A used swear words during the incident.

Corrective Action Plan : ARC Effective Response Training: The faculty member will complete the ARC Effective Response training program. This training will be conducted in collaboration with the Executive Director to ensure comprehensive understanding and application. Additional Training: The faculty member will complete at least two additional training modules available in the Paycor Learning Management System. These trainings will be selected based on relevance to the faculty member's role and areas needing improvement. Reporting and Follow-Up: Upon completion of each training, the faculty member will provide a verbal report to the Executive Director. The report will include key learnings, how the training will be applied in their role, and any further support needed. Review and Assessment: The Executive Director will assess the faculty member's progress. Regular follow-up meetings will be scheduled to discuss ongoing development and address any additional training needs.

Completion Date : 5/14/2025

Regulation number : He-C.4001.21.(o)(5)

He-C.4001.21.(o)(5) : Licensees shall provide sufficient numbers of personnel who are present in the program and are qualified to meet the needs of residents during all hours of operation.

Observation : The program reported that on March 2, 2025, Staff A used a hold with Resident A that was outside the scope of TCI (Therapeutic Crisis Intervention). Staff A described the incident, stating that they felt Staff B would not be able to react to assure Resident A's safety because they believed Staff B looked panicked by the event, so Staff A directed Staff B to leave with Resident B, leaving Staff A alone with Resident A during a physical interaction. Staff B stated that they are very cautious to place hands on with residents and that initially they froze during the incident, then Staff A told them to get Resident B out of the area, so Staff B walked down the hall by the kitchen door with Resident B, which is where Staff B radioed Hall Farm for support. Staff B further stated that, as a Community Leader, they knew they should have taken charge more during the incident. Staff C reported that, based on the incident report, Staff A and Staff B would not have been able to safely restrain Resident A without a third staff member to observe as well as supervise the other resident in the building. The review of the TCI reports from March 2, 2025, indicate that Resident A had "shown an uptick in explosive behaviors as of late and has been struggling to follow faculty redirection on a consistent basis." The video footage shows that the physical interaction began at 11:36:33 a.m. when Resident A pushed Staff A, Staff B called for support at 11:38:50 a.m., and two staff arrived in the building at 11:40:20 a.m. The department determined that the program did not assure that there were enough qualified personnel in the building during the time Resident A was present to ensure staff could safely restrain Resident A if necessary. This determination is based on statements by Staff A, B, and C, the staffs' knowledge of the increase in Resident A's behaviors over the previous days, and the review of records and video footage. Additionally, Staff A was alone with Resident A after directing Staff B to leave the area with Resident B.

Corrective Action Plan : Review and optimize staff scheduling to ensure adequate coverage at all times. Implement a system for flexible staffing to address peak times and emergencies. Work with Human Resource Coordinator and Program Manager to regularly evaluate staffing patterns and training qualifications. The faculty member is required to complete an additional 2 hours of TCI refresher training. The refresher training will cover key TCI principles, including crisis prevention, de-escalation techniques, and intervention strategies. Emphasis will be placed on practical application and real-life scenarios and increase competence and confidence. The faculty member will be required to complete a post-training assessment to demonstrate their understanding.

Completion Date : 5/14/2025

Regulation number : He-C.4001.22.(e)

He-C.4001.22.(e) : Program staff shall use restraint in accordance with RSA 126-U.

Observation : The program reported that on March 2, 2025, Staff A used a hold with Resident A that was outside the scope of TCI (Therapeutic Crisis Intervention). Staff A reported that on March 2, 2025, at around 11:30 a.m., they were in the common area of Blake House playing a game with Resident B. Staff B had just returned from the Hall Farm building with Resident A who was visiting with a family member, and Resident A was sitting on the floor doing an activity which they had just received as a gift from the visiting family member. Resident A started speaking over the conversation that Staff A was having with Resident B. Staff A stated that they attempted to redirect Resident A and asked them to stop. When Resident A did not stop, Staff A asked Resident A to go reset in their room for a few minutes, but Resident A did not comply. After several more prompts and Resident A's failure to comply, Staff A stated that they walked over to where

Resident A was sitting on the floor and started to pack up the activity. This agitated the resident, who grabbed Staff A's wrist with one hand, raised their other hand in the air in a fist, and told Staff A not to touch their "expletive" belongings and that they would punch Staff A in the face if Staff A touched their "expletive". Staff A responded by grabbing the booklet of directions for the activity and walking away. Staff A reported that Resident A immediately escalated and ran after Staff A, pushed them into the wall and placed their arm around Staff A's neck. A physical altercation ensued, and Resident A landed in a chair while they were entangled in a physical struggle, as further described in 22(e). The Individual Crisis Support Plan (ICSP) for Resident A identifies "Safety Concerns", including physical aggression towards faculty and peers (kicking, hitting, punching), "Current Issues/Potential Triggers" that cause changes in behavior, include feeling upset/frustrated/angry, being asked to follow a rule, structure, or expectation, being told "go to your room", and being touched. Under "Student's Level of Stress", triggering events include struggling to follow expectations, and signs of escalation include verbal and physical aggression. "Behaviors of Concern" (what staff see) includes threatening harm to others, verbal aggression (yelling, profanity), difficulty following rules, structures, and expectations. "Interventions for Faculty" include careful attunement, give explanations for expectations, redirect with their interests, use coping skills, maintain a calm tone, keep eyes on but give space, switch out targeted faculty, and remove the audience. The department determined that Staff A did not comply with RSA 126-U:3, I(b) when interacting with Resident A because they did not apply the strategies identified in Resident A's ICSP. Specifically, when Resident A failed to comply with Staff A's request to discontinue "butting in" and speaking over Staff A, they directed Resident A to go to their room to reset and began to pick up the activity that Resident A was doing. Resident A responded by telling Staff A not to touch their stuff or they would punch Staff A in the face if they did, after which Staff A grabbed the instruction manual and walked away, which is when Resident A escalated and ran after Staff A. Staff A did not recognize the identified behaviors that signal when Resident A escalates, nor did Staff A remove the audience, give space or switch out faculty.

Corrective Action Plan : Retraining on ICSP Utilization: Faculty will be retrained on the importance of utilizing each student's Individualized Crisis Support Plan (ICSP). The training will focus on identifying how to operationalize the information contained within the ICSP to effectively support students. TCI Refresher Training: The faculty member is required to complete an additional 2 hours of Therapeutic Crisis Intervention (TCI) refresher training. The refresher training will cover key TCI principles, including crisis prevention, de-escalation techniques, and intervention strategies. Emphasis will be placed on practical application and real-life scenarios. The faculty member's performance will be monitored to ensure the training has a positive impact on their ability to manage crises effectively. Additional training or support will be provided as needed to maintain high standards of care.

Completion Date : 5/13/2025

Regulation number : He-C.4001.22.(k)

He-C.4001.22.(k) : Physical intervention methods used shall be consistent with the curriculum required in (j) above and be reviewed annually with program staff to maintain competency.

Observation : The program reported that on March 2, 2025, Staff A used a hold with Resident A that was outside the scope of TCI (Therapeutic Crisis Intervention). Staff A reported that on March 2, 2025, at around 11:30 a.m., they were in the common area of Blake House playing a game with Resident B. Staff B had just returned from the Hall Farm building with Resident A who was visiting with a family member, and Resident A was sitting on the floor doing an activity which they had just received as a gift from the visiting family member. Resident A started speaking over the conversation that Staff A was having with Resident B. Staff A stated that they attempted to redirect Resident A and asked them to stop. When Resident A did not stop, Staff A asked Resident A to go reset in their room for a few minutes, but Resident A did not comply. After several more prompts

and Resident A's failure to comply, Staff A stated that they walked over to where Resident A was sitting on the floor and started to pick up the activity. This agitated the resident, who grabbed Staff A's wrist with one hand, raised their other hand in the air in a fist, and told Staff A not to touch their belongings. Staff A responded by grabbing the booklet of directions for the activity and walking away. Staff A reported that Resident A immediately escalated and ran after Staff A, pushed them into the wall and placed their arm around Staff A's neck. A physical altercation ensued, and Resident A landed in a chair while they were entangled in a physical struggle. Staff A stated that they directed Staff B, who was also present, to leave the common area with Resident B, because Staff A believed they were panicked by the event and that they should get out of the room for their safety. Staff B confirmed the incident and reported initially freezing in response, then directing Resident B to leave the community room, after which Staff B assisted Staff A by holding Resident A's wrist down on the cushion of the chair to prevent Resident A from hitting Staff A. Both Staff A and B reported that they did not initiate or conduct a compliant TCI restraint with Resident A and recognized in hindsight that the program policy warranted that they should have. The review of video footage revealed that Staff A and Staff B did not utilize a TCI compliant restraint when they held Resident A down in the chair and did not attempt to transition the resident into a different space or posture to safely implement a restraint in accordance with their TCI training.

Corrective Action Plan : Faculty member will receive follow-up training on the initiation of restraints, focusing on policy guidelines for when a restraint is warranted. This training will utilize the TCI curriculum, including the stress model of crisis. The follow-up training will include detailed instruction on the initiation of restraints, emphasizing policy adherence and the stress model of crisis.

Completion Date : 5/13/2025