



Child Care Licensing Unit

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

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I. Program Information

STATEMENT OF FINDINGS

ISSUE DATE : 7/28/2025

VISIT DATE : 7/23/2025

VISIT TYPE : Licensed Complaint

CORRECTIVE ACTION PLAN DUE DATE : 8/18/2025

Name of the program : MPA at Plymouth

Program address : 350 Main Street Plymouth New Hampshire 03264

License No. : CCRB-05691

Licensing Coordinator : Darlene Avery

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)

Program staff shall relate with residents in a professional, respectful manner.

Observation : The program self-reported that a staff member, Staff B, acted in an unprofessional manner by posturing aggressively and yelling at a resident, Resident A. Staff B stated that they did not handle an escalated situation with Resident A in a professional manner when they became angry and yelled at the resident while standing close to them. A review of the video recording shows Staff B standing in front of Resident A in a rigid posture while speaking to them. Resident A stated that Staff B was aggressive toward them and said unkind things to them.

Corrective Action Plan : The program self-reported that on 7/17/25, Staff B acted in an unprofessional and inappropriate manner during an escalated interaction with Resident A. Staff B acknowledged becoming angry and yelling at the resident while standing in close proximity. A video review confirmed that Staff B maintained a rigid and confrontational posture. Resident A reported that Staff B was aggressive and made unkind statements towards him. 1. Immediate Action Taken: The incident was reported promptly to internal program leadership with the program calling NH DCYF Central Intake and notifying licensing of the event on 7/17/25. Staff B was immediately removed from direct care duties pending investigation. The resident was assessed for emotional safety and offered support from clinical staff. A full review of the video footage and witness statements was conducted. 2. Root Cause Analysis: Inadequate Emotional Regulation: Staff B did not

effectively utilize de-escalation strategies during a resident crisis. Failure to Uphold Professional Boundaries: Staff B allowed personal emotions to influence their conduct. Need for Reinforcement of Trauma-Informed and Therapeutic Communication Principles: Staff did not reflect best practices in crisis interaction. 3. Corrective Actions and Preventative Measures: A. Personnel Action Staff B was placed on administrative leave after the incident on 7/11/25 pending the outcomes of the internal and external investigation. Upon conclusion of both investigations it was determined to move forward with the termination of the staff.

Completion Date : 8/4/2025