



Child Care Licensing Unit

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

TEL. 603-271-9025

EMAIL : ccluoffice@dhhs.nh.gov

I. Program Information

STATEMENT OF FINDINGS

ISSUE DATE : 9/4/2025

VISIT DATE : 8/18/2025

VISIT TYPE : Licensed Complaint

CORRECTIVE ACTION PLAN DUE DATE : 9/25/2025

Name of the program : MPA at Rumney

Program address : 1765 Route 25 Rumney New Hampshire 03266

License No. : CCRB-06690

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 4001.10(p)(2)

The applicant, licensee, or any child care staff shall not falsify any documents, other written information, or reports issued by or required by the department under He-C 4001.

Observation : Staff A reported that the room check log, which is recorded in the program's online documentation program, indicated that Staff B, the primary awake overnight staff on the community, had completed and documented the program-required 15-minute room checks. Staff A reported that they reviewed the cameras and found that room checks had not been completed as documented in the room check log between 11:29 p.m. and 1:38 a.m. Staff B confirmed they had not completed the required room checks, but had documented completing the 15-minute room checks in the room check log, thus falsifying the documentation used by the program to verify overnight supervision of residents in the program.

Corrective Action Plan : After this incident, an internal audit was completed around the electronic bed logs in the electronic documentation system that MPA at Rumney uses (Extended Reach) and additional gaps in training and deficits were discovered. Therefore, the Rumney AON team received re-training, re-education and verbal supervision around MPA's supervision policy (which includes 15 minute bed checks for skin, hair or movement) as well as re-training on completing and documenting bed checks. Moving forward, program administration will be checking for compliance around bed logs completed every night with accurate 15-minute time stamps attached to those bed check

logs. In addition, the AON team was re-trained on how to accomplish the 15 minute time stamps in the context of the bed log and, as identified above, will be checked with increased frequency moving forward to ensure fidelity to the 15 minute time frame. Lastly, Mount Prospect Academy is working towards Director (executive or program) daily approval of bed checks to ensure compliance with the MPA policy.

Completion Date : 8/27/2025

Regulation number : He-C 4001.14(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 reported that Resident A had eloped from the program at approximately 11:30 PM through their bedroom window, took a facility-owned manual scooter, and traveled to Plymouth, NH, until 1:30 AM, when Resident A turned themselves in at the Plymouth Police Department due to fatigue. Resident A confirmed they left the program around 11:30 PM after a room check conducted by Staff B, and reported that they stuffed their bed to make it appear that a figure was present in the bed, exited through their window, retrieved a manual scooter owned by the program, and left the premises. The program reported that the staff at the program were not aware of the situation until Staff A was contacted by law enforcement. Staff A reported that Staff B and Staff C were not aware that Resident A had absconded from the program until Staff A called, requesting that Staff B check Resident A's room. Staff A reported that Staff B had not conducted room checks every 15 minutes as required by the program's supervision policy. Staff C reported they had completed one bed check at the beginning of their shift, one hour before Staff B arrived at the program, but had not conducted a bed check on any resident room after their initial check. Staff B reported they had conducted a bed check on Resident B's room between 11:00 PM and 12:00 AM, and confirmed this was the last bed check completed before the phone call from Staff A to the program to advise that Resident A had eloped from the program. Staff B reported that they had completed the log after the incident was reported by documenting that room checks had been conducted per policy. Staff B and C both confirmed that the program's awake overnight supervision policy is to conduct room checks every 15 minutes, requiring staff to check for skin, hair, and/or movement. Resident B reported that Staff C would do bed checks every 15 minutes and that Staff B would do a bed check if Staff C or Staff D were not there. Resident B reported that bed checks had been consistent with Staff C and D. The review of the program's supervision policy confirmed Staff B and C's statements, adding that overnight staff must be certain that each resident is in their bed, safe, and sleeping. The review of video footage confirmed that bed checks did not occur between the last check of Resident A's room at 11:29 PM on August 9, 2025, and 1:38 AM on August 10, 2025, confirming the program staff did not supervise the residents per program policy during the overnight shift. Staff A reported that the program has increased overnight supervision and enhanced their evening bed checks, to ensure that lights are used to check on residents in their rooms. The program has also installed additional alarms on windows and doors in the facility. Additionally, Staff A reported Staff B had been placed on administrative leave.

Corrective Action Plan : As indicated in the observations column, immediate action was taken by the program; placing the faculty on administrative leave until the conclusion of the investigation and immediate directives were provided to the Rumney overnight team around completing bed checks every 15 minutes. On 8/27/25, re-training and education occurred with the MPA at Rumney overnight team which included reviewing MPA's supervision policy, AON job description and also identified expectations around supervision and task completion if there is an overnight staffed as a "floater" (an AON not directly tied into direct supervision of students on a community). The AON team was also re-educated on the process of notifying program administration of a student who absconds and two different scenarios that can occur if a student runs away (the first scenario was with faculty knowledge and the second scenario was if the student absconds without faculty knowledge) and different outcomes to those scenarios. As indicated in the above

complaint and response, MPA at Rumney plans to conduct more frequent quality assurance checks around overnight supervision and increased scrutiny around the time stamping of the checks on the overnight logs.

Completion Date : 8/27/2025