



Child Care Licensing Unit

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I. Program Information

STATEMENT OF FINDINGS

ISSUE DATE : 10/21/2025

VISIT DATE : 10/6/2025

VISIT TYPE : Licensed Complaint

CORRECTIVE ACTION PLAN DUE DATE : 11/11/2025

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 4001.14(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 on September 30, 2025, Resident A reported that on August 23, 2025, an incident occurred between them and Resident B when they were unsupervised during an off-site programming trip which resulted in inappropriate contact between the residents. Resident A reported to the program that they and Resident B were unsupervised for five minutes, and Resident B reported to the program that they and Resident A were unsupervised for one to two minutes. Resident A stated to department staff that they were off site with Residents B, C, and Staff A, and that they and Resident B were riding bicycles, Resident C was on a scooter, and Staff A was walking. Resident A stated that they and Resident B went ahead of Staff A and Resident C, resulting in them being out of Staff A's supervision for a minute or two before Staff A arrived, adding that Staff A could see them until they reached the gate at the location. Resident A further reported they should not have gone ahead and that Staff A had told them they should have stayed with Staff A. Resident B stated to department staff that they and Resident A were riding bicycles, Resident C was riding a manual scooter, and Staff A was walking to the off-site location and that Residents A and B had gone ahead of Staff A and Resident C, resulting in them being alone and out of staff supervision for five minutes. Resident B further reported that Staff A likely attempted to redirect them and

Resident A to not leave supervision, but both reported they could not hear Staff A. Resident C stated that Residents A and B had gone ahead of them and Staff A, resulting in them being out of staff supervision. Resident C stated that Staff A told them to go ahead to meet Residents A and B, and that they (Resident C) caught up with Residents A and B before Staff A, who arrived about five minutes afterwards. Resident C reported that Residents A and B were not listening to Staff A, and that Staff A continued to ask Residents A and B to stay with them, but Residents A and B did not listen to Staff A. Staff A reported that while going to a nearby off-site location, Residents A and B were riding bicycles and had gone ahead of them and Resident C, despite Staff A's requests for them to come back. Staff A reported they told Resident C, who was on a scooter, to go ahead and that they would catch up, and that Residents A and B were out of visual supervision for approximately one minute. The program's supervision policy CM 002, specifically states for offsite programming that "Faculty are required to maintain eye contact supervision off-campus in all circumstances unless approved specifically by the Treatment Team." The department determined that Staff A did not provide the required level of supervision when they opted to walk to the off-site location when two residents rode bicycles and one was on a scooter, and when Staff A directed Resident C to go ahead of them, all of which resulted in the residents being out of Staff A's direct supervision.

Corrective Action Plan : Summary of Deficiency - On August 23, 2025, Staff A failed to maintain required supervision during an off-site recreational activity. Staff A chose to walk while residents used bicycles and a scooter, creating conditions where visual supervision was lost for approximately 1–5 minutes. Staff A's decision to allow differing transportation modes and instruct a resident to proceed ahead contributed to the supervision lapse. This is a direct violation of supervision policy CM 002 and DHHS Child Care Licensing standards regarding visual supervision of minors. Root Cause Analysis - Staff Decision-Making: Staff A used poor judgment by allowing multiple modes of travel (bikes, scooter, walking) without adjusting the plan to maintain visual proximity. Pre-Trip Risk Assessment: There was no documented assessment or adjustment to ensure supervision feasibility given the transportation differences. Policy Reinforcement: Inconsistent application and recall of the supervision policy for off-site activities. Environmental Factors: Open terrain and distance contributed to temporary loss of sight, but the primary cause was a preventable staff decision. Corrective Actions Taken - Immediate Response: Staff A was removed from direct off-site programming pending review. Incident Reporting: The program self-reported the supervision lapse to the Department as required. Staff Coaching, Supervision and Re-training: Staff A received immediate coaching regarding supervision expectations and off-site safety protocols. In addition, a previously signed copy of off-campus expectations specific to supervision of students with problematic sexual behavior was brought to Staff A's attention. Resident Support: Clinical follow-up occurred with all involved residents to ensure emotional safety and address boundary education. Operational Changes: Moving forward at MPA at Rumney there will not be mixed modes of transportation (Ex. faculty walking and students riding bikes, scooters, skateboards, etc.) on off-campus trips and programming.

Completion Date : 10/8/2025