



Child Care Licensing Unit

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I. Program Information

STATEMENT OF FINDINGS

ISSUE DATE : 2/13/2026

VISIT DATE : 1/28/2026

VISIT TYPE : Licensed Complaint

CORRECTIVE ACTION PLAN DUE DATE : 3/6/2026

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 : Program staff notified the department that a resident was without supervision on January 22, 2026. Staff A reported that Resident A had absconded from the program in the early morning near the end of the overnight shift. Overnight staff had completed the program's required 15-minute bed checks, but had assumed that Resident A was in their bathroom, which was located within Resident A's bedroom, resulting in a lapse in supervision. Staff B reported Resident A was awake before 5:30 a.m. and had requested toilet paper for their bathroom. Staff B reported that at the next bed check at 5:30 a.m., Resident A's bathroom light was on with the door closed. Staff B stated they thought they heard feet shuffling in the bathroom and assumed Resident A was using the bathroom, so Staff B did not knock on the door or call out to give Resident A some privacy. Staff B reported that they completed another bed check at 5:45 a.m. and believed Resident A was still in the bathroom, as the light remained on with the door closed. Staff C reported completing their hourly bed check at the beginning of the hour, at 6:00 a.m., and reported to Staff B that Resident A still appeared to be in their bathroom. Staff B indicated that they would make sure Resident A was okay if Resident A was still in the bathroom at the next room check. Staff B reported that at 6:15 a.m., they checked the bathroom and found that Resident A was not in the bathroom or the bedroom. Staff C

confirmed Staff B's statements and reported they saw footprints in the snow on the deck outside Resident A's bedroom window, proceeding down the stairs of the deck. Staff C stated they called Staff A to report that Resident A had left the program. Staff C stated that, after program staff initiated a search, Resident A was found walking along the road, and Staff D assisted and brought Resident A back to the program. Staff A and Staff D reported they reviewed video footage and verified that staff conducted bed checks as required every 15 minutes, but that Resident A had left the program between the 5:15 a.m. and 5:30 a.m. bed checks. Staff A and D both reported that staff were completing bed checks consistently, but reported that both staff indicated they had assumed but did not verify that Resident A was in the bathroom. The licensing coordinator's review of video footage verified the program was conducting 15 minute bed checks as required by their program overnight policy and as reported by Staff A, B, C and D. Resident A reported they left the program before the 5:30 a.m. bed check and had left the light on in the bathroom with the door closed hoping that this would cause the staff to think he was in the bathroom. The video footage also verified that Resident A left the program between the 5:15 a.m. and 5:30 a.m. bed checks through their bedroom window, as reported by Resident A. Resident A verified that program staff conduct bed checks every 10 to 15 minutes, and Resident A reported that they typically verbally indicate that they are in the bathroom during a room check. Staff B and C reported the program's policy was to check the residents' rooms every 15 minutes throughout the evening, and to check for hair, skin or movement, and to document the bed check on the computer, but both Staff B and C reported there was not a policy for verifying residents were actually in their bathrooms located in their bedrooms during bed checks.

Corrective Action Plan : Summary of Deficiency - On January 22, 2026, a resident absconded from the program during the early morning hours between the 5:15 a.m. and 5:30 a.m. bed checks. Overnight staff completed required 15-minute bed checks in accordance with program policy. However, staff assumed the resident was in the bathroom due to the bathroom light being on and the door closed and did not verify the resident's presence. The resident had exited through the bedroom window and left the light on intentionally to give the appearance that they were still in the bathroom. The resident was located shortly thereafter and returned safely to the program. The program identified that while staff were completing required checks, there was not a clearly defined policy/procedure requiring staff to verify resident presence in a bathroom located within a bedroom during bed checks, which contributed to the lapse in supervision. Immediate Corrective Action - Immediately following the incident: -Program leadership reviewed the incident with the overnight staff involved. -Staff were instructed that assumptions regarding resident location are not acceptable during supervision checks. -Staff were directed that if a bathroom light is on and the door is closed during bed checks, staff must: -Knock on the door and verbally confirm the resident's presence, or visually verify the resident is in the bathroom (through sound or movement) A search protocol was immediately implemented once the absence was discovered, and the resident was safely located and returned to the program. Policy and Procedure Changes: the program has revised its overnight supervision and room check procedures to require: -Positive verification of resident presence during every bed check. Staff must visually confirm the resident or receive a verbal response if a resident is in the bathroom. Bathroom verification protocol: If a bathroom door is closed: -Staff must knock and verbally check on the resident. -Staff must receive a response or visually/auditorily verify occupancy Escalation procedure. If verification cannot be obtained, staff must immediately: -Re-check the room. -Notify additional staff. -Initiate internal search procedures. Window and exit monitoring. Overnight staff will also verify that bedroom windows are secure during overnight checks. These procedures have been incorporated into the program's overnight supervision procedure. Staff Training: All overnight staff will receive training on: -Updated overnight supervision and verification procedures -Maintaining active supervision and avoiding assumptions -Absconding risk awareness and response protocols -Documentation expectations during bed checks Training will occur through: -Immediate shift meetings -Pre-shift supervision training -Documentation review and sign-off Monitoring and Quality Assurance -To ensure ongoing compliance: -Supervisors will conduct random overnight supervision audits. -Leadership will review bed check

documentation and camera footage periodically to verify compliance with verification procedures. -Any identified concerns will be addressed through coaching, retraining, or corrective action if necessary. The program will also incorporate this incident into ongoing staff training and risk management review to strengthen supervision practices.

Responsible Parties: Residential Operations Director / Program Director, Shift Supervisors

Completion Date : 2/18/2026