The Gresham Care Home Limited

Gresham Care Home

Inspection report

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Date of inspection visit:
27 November 2017
30 November 2017

Date of publication:
29 January 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 27 and 30 November 2017 and was unannounced. Our previous inspection of 26 and 28 September 2016 had identified breaches of two regulations relating to safeguarding and the failure to submit statutory notifications to the Commission when incidents had occurred in the home. This November 2017 inspection found that improvements had been made in both areas and that the provider was no longer in breach of these regulations.

Gresham Care Home is a 'care home'. It provides nursing care for up to 39 people in one adapted building. At the time of this inspection 35 people were living there. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was in post. They were also a qualified nurse and one of the two partners in the business. We have referred to this person as the manager in this report. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst we were satisfied that there were no breaches of regulations we have made two recommendations, one that the provider review their procedures for monitoring food and fluid intake and another that the provider review their quality assurance processes.

Staff were trained and understood their responsibilities in relation to safeguarding. Risks to people's welfare were identified and action plans were in place to minimise the risks to people's welfare as far as was possible. The premises was well maintained and kept clean which helped reduce the risks to people from cross contamination. People's medicines were managed and administered to them safely.

There were enough staff on duty to meet people's needs. There was a high ratio of staff to people living in the home as many people were living with complex health conditions which meant that two staff members were often required to support people. Recruitment processes were robust.

People received the support they required with their nutrition. Some people had cultural or religious dietary requirements; others had chosen to restrict their diet to certain food types. All of these individual requirements were catered for.

Staff received the training and support necessary for them to perform their roles effectively. The manager's ethos was to expand the knowledge range and skills of their staff.

People's day to day health care needs were met. When necessary staff obtained the advice and support of other health and social care professionals.

The staff were attentive, caring and treated people with respect and kindness. People's views about their care were sought and acted upon. When appropriate the service involved people's relatives in helping to determine the care people needed and how the person would wish to be supported.

Care was person-centred and was responsive to people's needs. Any concerns and complaints were investigated. People and their relatives were confident that the service would act in a fair and responsible manner to resolve any concerns promptly.

The service was well led and held in high regard by people living in the home, their relatives, the staff and health professionals. However, quality assurance systems needed a review to ensure that they were fit for purpose and would identify any concerns if they were to arise.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received safeguarding training and demonstrated a good knowledge of what abuse was and how to report any concerns.

Risk's to people's welfare were identified and acted upon.

There were enough staff to meet people's needs. Robust recruitment practices were in place.

People received their medicines as prescribed for them.

Good cleanliness and infection control practices helped protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

People received suitable support with their nutritional needs. However, we have recommended that the provider reviews their procedures for the monitoring of people's food and fluid intake.

The manager placed a high value on staff training and provided a good standard of training and support to care and nursing staff.

Staff ensured that people consented to their care or acted in people's best interests when appropriate.

Is the service caring?

Good

The service was caring.

People told us that they felt well cared for and the staff were caring.

We observed that people's privacy and dignity was respected at all times.

Is the service responsive?

Good

The service was responsive.

Care plans contained details of people's preferences and choices regarding the care and support they required.

The provider had systems in place to receive and address any complaints that were made.

Is the service well-led?

Good

The service was well led.

Whilst we found no serious concerns we have made a recommendation about strengthening governance arrangements in the home.

People, their relatives and staff were supportive of the manager.

Gresham Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 and 30 November 2017 and was unannounced. It was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us over the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local authority for their views on the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with six people living in the home and relatives of five people living in the home. We also spoke with both partners in the business (one of whom was also the manager), two nurses, four care staff members and administration support staff.

We reviewed the care records for three people in depth, specific care records for five other people and the medicines records for four people living in the home. We also looked at records in relation to the management of the home. These included the recruitment files for three staff members, staff training records, compliments and complaints, quality monitoring audits and minutes from meetings held.

Good

Is the service safe?

Our findings

Our previous inspection of 26 and 28 September 2016 identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate actions had not been taken in relation to incidents that should have been referred to the local authority's safeguarding team. At this November 2017 inspection we reviewed all incidents and complaints for the previous 12 months and found no repeat of these concerns. We spoke with the manager and several staff members, all of whom had a good understanding of what concerns might require a safeguarding referral to be made. All staff had received up to date training in this area. The provider had safeguarding and whistleblowing policies and procedures in place.

Consequently, the provider was no longer in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living in the home. We saw that people who been assessed as needing a dedicated staff member present with them for specific hours in the day received this level of support. Clinical staff took sensible precautions when they were concerned about a person's health whilst waiting for the support of specialist health professionals. For example, one person who received their nutritional intake via a feeding tube into their stomach had been assessed as safe to have a few teaspoons of pureed food orally each day. However, they had recently become wheezy. Clinical staff had discussed their concerns with the person and it had been agreed that this would stop until a specialised evaluation had been carried out.

Risks to people's safety and welfare were identified and plans were in place to mitigate these risks. These risk assessments and action plans were regularly reviewed and covered areas such as nutrition and hydration, skin integrity, falls and risks relating to specific health conditions people were living with, for example diabetes.

Some people's nutritional care plans contained conflicting information about the texture of food they required or failed to mention that their drinks required thickening to aid swallowing. Information wasn't always carried over correctly or fully from speech and language therapists' assessments. We carried out several checks and were satisfied that in practice, people received the correct support and that staff knew what each person's requirements were. The manager told us that they would review and update nutritional care plans accordingly.

Health and safety risk assessments and checks in relation to the environment and equipment were completed as necessary. Our September 2016 inspection had noted some weaknesses relating to the management and safety of the water system. These had been remedied.

Accidents and incidents that occurred were recorded and reviewed by the registered manager. We were satisfied that appropriate actions were being taken in relation to falls, for example, referrals were being made to the falls team and changes in equipment or the way care was provided were made. However, there was no demonstrable system to identify whether there were any patterns or trends in the falls, for example,

the location of the fall or time of day. This could help the service to plan to reduce re-occurrences of events in the future.

Most people told us that there were enough staff to meet their needs. One person said, "There seem to be enough staff. They come when I call them." Another person said, "Sometimes there are enough staff, sometimes not." A third person told us, "I generally have to wait five minutes, sometimes 10 if they are busy. I don't stress about it. I've got confidence in the staff and know that they'll come as soon as they can."

We found that there were enough staff to meet people's needs. At the time of this November 2017 inspection there were 35 people living in the home. In addition to nursing staff, nine or 10 care staff were required on each day shift as many people required two staff to support them with mobilising and personal care. A large proportion of people living in the home required staff assistance to eat and drink. Overnight there was a nurse plus four care staff members.

A few people were able to use their call bells to summon assistance if needed, but most people living in the home were not able to do so. Staff told us that they were allocated to work in specific areas of the home and regularly checked on people in their rooms to make sure that they were okay and to provide regular care, for example to assist them with food and drink, administer medication or to help them reposition. Whilst there were no specific records to show how often people were checked upon, records for meals, repositioning and administering of medication confirmed that people were regularly attended to. During both days of our inspection we found that people unable to use their call bells were not in any distress and appeared content and well cared for. We saw that staff were available throughout the home and frequently went in to people's rooms to check their wellbeing when no direct care was required at the time.

Robust recruitment processes were in place to help reduce the risks of recruiting staff unsuitable for their role. These processes included obtaining references, proof of identification and checks made with the Disclosure and Barring Service.

People told us that they received their medicines as required. One person told us, "I have tablets three times a day. The staff give me them in a pot and I take them straight away." Another person said, "I get my tablets regularly." A third person told us, "I have five at breakfast time and two with my supper. No fuss."

During the week of our inspection the service had changed to a biodose medication system. This is a monitored dosage system that can incorporate many liquid medicines, as well as medicines in tablet form. People's tablets were in one pod for each medicines administration round, for example morning or afternoon with any liquids in another. Each pod had the person's name on and details of the medicines contained within it. Medicines were delivered on a weekly basis and clinical staff use pictorial guides and descriptions to check the contents of each pod upon delivery. They were checked again against the Medicines Administration Chart (MAR) prior to administration to people.

The manager and nurses were positive about the system and felt that medicines administration would be easier and safer as a result of this new system. Their implementation was going well so far.

Protocols were in place where medicines had been prescribed on an 'as required' basis. Medicines where the prescription changed regularly, for example warfarin, were not part of the biodose system. We checked and found that warfarin was being administered safely. Where necessary opening dates were recorded on medicines, for example creams and eye drops. All medicines were found to be in date. Application positioning and removal charts for medication patches were in place to help ensure that people did not develop skin irritations where patches were applied. We were satisfied that people received their medicines

as prescribed for them.

The home was clean throughout and odour free in all areas. We checked communal areas, people's rooms and bathrooms. One relative told us, "My family member has been doubly incontinent for some time now. I visit very regularly and have never smelt anything unpleasant in the home." People we spoke with told us that their rooms were always clean. One person said, "My room is cleaned every day. If it hadn't been cleaned this morning you would have seen all the tinsel left by my grand-daughter yesterday!" We saw that staff adhered to appropriate use of protective aprons and gloves when supporting people. Room audits were in place which included cleanliness checks. However, these did not cover all areas of cleanliness and infection control practice. We discussed this with the manager and by the second day of the inspection they had sought practical support on infection control auditing from health professionals.

Good

Is the service effective?

Our findings

People were positive about the food. One said, "It's very nice. I am having curry today." Another person told us, "It's lovely food here, hotel quality." A third person told us, "The food here is really good, you can see that I've put on weight."

We saw that few people had drinks available to them throughout the day outside of mealtimes. The manager explained that many of the people living in the home needed the full assistance of staff to eat and drink and that they preferred staff to prepare fresh drinks throughout the day for them. Staff confirmed this to us and said that if they had any concerns about people not drinking enough, this would be reported to the manager or nurse on duty and fluid charts would be implemented. Fluid records were not routinely kept for people requiring the assistance of staff to drink. If people were prescribed nutritional supplements in the form of high calorie drinks the administration of these was recorded on people's MAR charts. A fluid balance chart was kept in respect of one person who was at risk of urinary retention.

The manager told us that no-one was having their food intake recorded. The service's weight recording report showed that three people were of a low weight. The weights for two of these people were slowly but steadily increasing. One person's relative told us that staff spent a lot of time trying to encourage their family member to eat and that different foodstuffs were frequently tried to try and tempt them.

Records for the third person whose weight was steadily reducing showed that they often declined food and that the service had sought the input of relevant health professionals. However, no records were kept in relation to the person's daily intake. Therefore, the manager could not assure themselves or demonstrate to health professionals that all possible actions were being taken to support the person with their nutrition.

We recommend that the service review its arrangements for the recording and monitoring of food and fluid intake and document its procedures accordingly. This review should clarify the criteria used to determine when recording and monitoring of food and fluid intake would be required. It should also consider how the service can clearly demonstrate that people at risk of not eating and drinking enough receive suitable nutritional support.

We observed meal times and found that people received the necessary support from staff with their meals. Staff were patient and did not rush people. However, we noticed that desserts were served at the same time as the main meal. We had noted this during our September 2016 inspection. This practice may have put people off of their main course or made people feel rushed. This is not indicative of personalised care. We were told that snacks were available, but found that none were on the drinks trolley as it went around the home. We were told that those that could eat unassisted just asked for something if they required it.

We saw that considerable lengths were gone to to ensure that people received food they enjoyed or to comply with their religious or cultural beliefs. There were many one off arrangements in place to ensure this. One person liked coconut cream in their porridge. Another person required bread made with altar dough for receiving communion.

People's care records showed that their care preferences were determined as well as their care needs. Staff told us about people's preferences and how they adapted the support they provided to people to ensure that they received care in a way that suited them. The manager ensured that people received care and support in accordance with up to date guidance and best practice.
The manager was pro-active in ensuring that staff were supported to receive all relevant and necessary training, practical support and guidance.

They ensured that the nursing staff's professional registrations were current and helped facilitate this by enabling nurses to keep their skills and knowledge up to date. The manager and nurses attended a variety of training updates and depending on the subject conveyed this back to other nursing staff. We saw that clinical updates had been provided to nursing staff on stoma care, end of life care, feeding tubes, infusion pumps used to relieve symptoms of Parkinson's disease, diabetes and the Situation, Background, Assessment and Recommendation communication method. This is a way of conveying urgent clinical information quickly and effectively to obtain the best outcomes for people promptly. Nursing competencies were tested. These included verification of death, catheterisation, the usage of syringe drivers and oxygen therapy.

Care staff undertook the provider's mandatory training programme. In addition the manager provided awareness sessions of clinical aspects of care to greater enhance the skills and knowledge of care staff. Staff appreciated this level of interest in developing their knowledge. One staff member told us that they had attended sessions given by the manager on skin tears and were due to attend external extensive training on understanding urinary tract infections and the prevention of falls. Staff were supported with regular supervisions and appraisals.

People told us that staff were competent in their duties. One person said, "They know what they're doing. I don't get concerned at all. There are always two staff to help me move between my bed and the chair." Another person told us, "There's a few new staff recently. I watched them shadowing others whilst they learn." One person's relative told, "I visit at all different times in the week and at weekends. The consistency of care is always good in the home, whenever I go in."

We found that the service worked well with health professionals to ensure that people received effective care, support and treatment. Staff ensured that people were supported by a wide range of health and social care professionals including GPs, dentists, the mental health team, speech and language therapists and specialist nurses. The service shared information appropriately with other health professionals.

We reviewed recent feedback provided by health professionals, all of which were positive. One review stated, "Staff and nurses are always professional, helpful and very knowledgeable. The service is well managed and they seek support and guidance when necessary." Another review said, "[The nurse] was able to provide full and accurate information on all residents I was reviewing today. All of our recommendations are followed through." A third review stated, "The service takes good care of residents with complex needs."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes

and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that it was.

The manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. We found as a result, that they had applied to local authority to restrict the liberty of several people living in the home. These applications were appropriately made. When people's needs changed further applications were made as necessary. However, none as yet had been assessed by the local authority.

Staff worked within the principles of the MCA and were trained to understand the implications of this and how it related to the day to day care and support they provided to people. Consent was obtained from people in relation to different aspects of their care, with records showing how the person had demonstrated their understanding. Mental capacity assessments had been carried out when necessary, which lead to decisions being made in people's best interests in consultation with relevant people.

Since our last inspection the provider had installed a second lift, large enough to hold a stretcher to help ensure people who were immobile could be moved between floors. The manager told us that they were planning to make the garden more accessible by levelling walkways where possible. They had consulted people about their plans to add further bedrooms to the home and had plans in place to limit the impact upon people whilst work was underway.

Good

Is the service caring?

Our findings

People and their relatives told us that that they or their family members were well looked after and the staff were caring. One person told us, "Nothing is too much trouble for staff. I am comfortable and cared about." Another person said, "The staff are very kind. They are very careful when hoisting me, particularly if my back is hurting that day." A third person said, "They treat me with absolute respect." One person's relative told us, "Everyone is so accommodating and helpful. Whatever we ask for is no trouble, it's just done. I have seen staff who don't know I am here go into [family member's] room before me. They speak kindly to [family member] even when there is no response. When they use the hoist they re-assure [family member]."

We observed positive interactions between staff and people using the service. People were relaxed in the presence of staff, smiling and chatting. During the lunchtime period those who were able to were encouraged to eat independently. A relative told us, "Sometimes [family member] can feed themselves, sometimes they can't. Staff are careful to watch first and see how they get on before rushing in. They help [family member] maintain as much independence and dignity as possible. And that is important to them."

Staff spoke positively about their roles and knew the people they cared for well. They were aware of people's personal histories, knew who their visitors were by name and demonstrated a good understanding of their needs and preferences. One staff member told us in detail how one person liked to receive their personal care and the lengths staff went to in order to make sure the care provided was provided in the specific way that made the person happy.

Only a few people living in the home were able to express their views in any detail. Those we spoke with told us that they were consulted about their care and given whatever information was necessary for them to make their own decisions. One person told us that after a visit from the GP a nurse would often go back and spend more time with them explaining things in a bit more detail and providing assurance when necessary.

The manager told us that they had tried having resident and relative meetings in the home, but these had proved successful. Few people living in the home wished to attend meetings and relatives did not attend either. Where people were not able to participate in discussing their care where appropriate the manager ensured the home communicated regularly with people's family members or representatives. There were records of these contacts and a rolling programme of contacts was in place. Relatives told us that staff were pro-active in keeping them informed about their family member's care or any incidents that took place. One relative told us, "I have complete peace of mind. My [family member] is inclined to have the odd bump; they have been like this for years with their health condition. I know that I will always be told what happened, how it happened and what action was taken. I know they do all they can for [family member]."

We observed that people's privacy and dignity was respected at all times. Personal care took place behind closed doors. We observed that staff knocked on doors before entering. If people chose to spend time in their room their decision was respected. We observed staff checking on people's welfare in their rooms periodically throughout the day.

Good

Is the service responsive?

Our findings

People's care records were on a computerised system which contained details of people's preferences and choices regarding the care and support they received. Care plans and risk assessments were regularly reviewed. Care plans were drawn up and updated by the manager, nursing and some senior care staff members.

We asked staff without access to these records how they knew about the care people required. Staff told us that when new people came to live in the home the manager would provide a detailed, but concise, verbal summary of their care needs to them. Staff always carried handbooks and wrote down salient points to refer to and to record care duties such as when repositioning was carried out. They told us that shift handover sessions were also very detailed in the home as many people had complex needs which might change on a day to day basis. They told us that they had access to printouts from the computerised system, but felt that the level of support and information provided to them when people moved in to the home, and more importantly during handover sessions, was more than sufficient to provide them with the up to date information they needed.

Several people chose to stay in their rooms. The manager and staff were keen to avoid people being socially isolated and encouraged people to spend time communal areas, but respected the wishes of those who chose not to do so. One person's relative told us, "I know staff would like [family member] to spend more time with others and I would love [family member] not to spend so much time alone, but this is what they want to do."

People received care that was personalised to them and responsive to their needs. A relative had commented in a recent survey, "They take time to understand [family member] and what is important to them. They make sure she has her handbag with her and makeup applied at all times." One relative told us, "Staff never fob me off here. They always try to find the right solution for [family member], not what suits the home best."

On one day of our inspection we observed a game of bingo taking place in the lounge with about eight people taking part. Staff were supporting some of these people to participate. It was clear this was a regular event as people clearly understood the 'rules' of the bingo game being played. We saw that some ladies were having their nails painted. Staff told us that they facilitated some people to do arts and crafts and read to others, but many people were not well enough to engage fully. A 'music man' attended the home weekly which people enjoyed. One staff member was specifically engaged for six hours in the week to take people out individually. This was often to the town centre to do some shopping or for a visit somewhere. Another staff member was engaged for four hours a day to assist people with social engagement, do activities or support people with their own interests.

We reviewed the complaints the home had received in the 12 months prior to our inspection. Most of these had been resolved verbally to people's satisfaction. The manager told us that they would respond in writing if people preferred this. The people we spoke with and relatives of others living in the home told us that they

no complaints about the home. If they were to have any concerns they were satisfied that their concerns would be investigated and responded to satisfactorily.

The home worked closely with local GPs when people's lives were drawing to a close and provided a good standard of care and support. This was extended to people's families too. One person's relative told us that the staff would sit with people in their final hours if relatives were unable to be there. We saw cards from relatives thanking the staff for the care they provided and ensuring that their loved ones were pain free in the final stages of their lives.

Good

Is the service well-led?

Our findings

Our previous inspection of 26 and 28 September 2016 identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because appropriate statutory notifications had not been reported to us in relation in relation to two safeguarding issues. At this November 2017 inspection we reviewed all incidents and complaints for the previous 12 months and found no repeat of these concerns. We spoke with the manager who had refreshed their knowledge about notifications that needed to be made to the Commission.

Consequently, the provider was no longer in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was not a cohesive quality assurance system in place. Instead of a clear infection control and health and safety audits with sample checks built in there were individual clerical booklet records for each bedroom and various communal rooms and areas. The booklets for bedrooms contained a tick list of items that said wires, plugs, sockets, décor, buzzer, cleaning, toilet sink and taps. The booklet for the sluice room listed fittings, lighting, décor, cleaning sink and taps descaling. However, the booklets did not specify what needed to be checked in each of these areas. There was also a clerical infection control 'to do' list relating to the environment which had dates and signatures to show when actions required had been completed. However, this did not cover any clinical aspects of infection control.

Staff training records were held on a complicated system from which staff had been unable to extract a summary of outstanding staff training during our inspection. This meant that the manager had no easy oversight of the staff training position in the home. Following a discussion about this the provider subsequently commenced using their computerised care system which had the capability to do this. There was no effective analysis of incidents and accidents in the home.

We were provided with several hardback ledgers which recorded details of staff training sessions, meetings and discussions held with family members, each of which could be held on the computerised care system.

There was a system of surveys in place to obtain the views of people in the home, their relatives and visiting professionals. However, there was no staff survey. The survey for people living in the home only concerned their mealtime experiences. Few people living in the home were able to complete the survey and some of these had completed it four times in a year. The results from every survey completed were positive.

Despite the above points, we found no significant areas of concern in the home. The manager's primary focus was on the day to day care of the people living in the home. We were satisfied that this was provided to a good standard. However, we are concerned that if areas of concern were to arise in the home, some of the quality assurance systems in place would not be robust enough to identify them.

Consequently, we recommend that the provider obtain suitable support to carry out an assessment of their quality control and governance systems, with a view to modernising, strengthening and streamlining them.

Staff told us that they enjoyed working at the home. They told us that there were good relations between staff, that the manager worked hard and had a good ethos which they shared. Several had worked in the home for many years. One of them told us, "I've worked here for about 19 years but I am not the record holder. Everything runs pretty smoothly here. This is my second family and I am proud to work here and proud of the care we provide for people." Another staff member told us, "This is my first job in care and I've learnt so much. I like the people I work with, and I love the residents. The manager is good to work for and she's always on top of everything."

One relative told us that the staff group was generally stable and respected and were loyal to the manager. They had seen that new staff were welcomed and supported when joining the service. They added, "The manager's heart is in the right place." Another relative said, "I wouldn't hesitate to recommend the home. A lot of other homes could learn a lot from The Gresham. It's a wonderful place."