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Grove Villa Care

Inspection report

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Date of inspection visit:
23 July 2018
24 July 2018

Date of publication:
21 August 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 23 and 24 July 2018 and was unannounced.

Grove Villa Care is a 'care home'. 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. Grove Villa Care accommodates 16 people in one adapted building. There were 15 people using the service at the time of our inspection. People using the service had a range of physical and learning disabilities. Some people were living with autism and some required support with behaviours that challenged.

The care service had not been developed and designed in line with the values that underpin Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People were not supported to live an ordinary life, like any citizen.

A registered manager was employed to manage Grove Villa Care and two other services the provider owned on the same site. The registered manager was not present at the time of our inspection and was not leading the service. 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.

We inspected Grove Villa Care on 20 April 2017 and 18 January 2018 and found significant shortfalls. The service was rated inadequate on both occasions and placed into special measures.

Following our April 2017 inspection, we placed a condition on the provider's registration, requiring them to send us monthly reports about the actions that had been taken to meet the breaches of regulations found at the inspection. We have not received some these reports as required.

At our last inspection we found that the registered persons had failed to ensure that staff had the necessary guidance to keep people safe. Staff had not been recruitment safely and staff were not appropriately trained and competent to carry out their roles. People were not treated with respect and dignity and did not received person-centred support to communicate their needs. People were not involved in planning their care and had not been supported to take part in pastimes they enjoyed. The registered persons had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. People views were not used to improve the service and suitable arrangements were not in place to maintain accurate and complete records. CQC had not been notified about significant events that happened at the service in a timely manner.

We took regulatory action against the provider after our inspection in January 2018 and this is ongoing. Full information about CQC's regulatory response to the serious concerns found during our inspections is added

to reports after any representations and appeals have been concluded.

The service is in special measures. We kept the service under review and inspected the service again within six months to check that the significant improvements required had been made. At this inspection we found that minor improvements had been made in some areas, however there were still serious concerns regarding the registered person's oversight and overall management of the service. Some breaches of the regulations continued and there were new breaches of other regulations.

The registered persons did not have oversight of the service. Checks and audits of the service had been completed in some areas of the service but these had not identified the shortfalls we found during our inspection. Lessons from previous inspections had not been used to improve the service and there continued to be breaches of five regulations. The views of people, their relatives, staff and community professionals were not obtained or acted on to continually improve the service.

Staff had not been deployed to provide people with the care and support people needed when they wanted it and people were not supported to be independent and achieve their goals and aspirations. People did not always receive the support they needed when they requested it. Staff had not been fully supported to consistently promote people's dignity by treating them with respect. Plans had not been put in place with people since our last inspection to make sure people received care and support in the way they preferred at the end of their life. Records in respect of each person and governance processes were not accurate, complete and kept securely.

Assessments of people's needs and some risks had not been completed and care had not been planned with people, to meet their needs and preferences and keep them safe and well. Accidents and incidents had not been analysed to look for any patterns and trends. At our last inspection we found that there was still a lack of essential guidance for staff if people were at risk of choking. At this inspection we found that this guidance was available in people's care plans.

People were not fully protected from the risk of fire and staff did not know how to support people to remain safe in an emergency.

Changes in people's health were identified and people were supported to see health care professionals, including GPs when they needed. However, professionals' advice had not always been followed on to keep everyone well and support them to share their views and choices.

Incidents had not been recognised as potential safeguarding incidents and had not been shared with the local authority safeguarding team so they could be investigated. Some people were isolated. People did not have enough to do during the day. Activities were not planned around each person's preferences and people were not supported to continue to develop their independent living skills and achieve their goals.

The provider's complaints process had not been followed and complaints had not been robustly managed to ensure that they were thoroughly investigated and quickly resolved.

Mealtimes were not a positive experience, some people had to wait for the support they needed and other people's meals were interrupted when staff left them to support others. People were offered a balanced diet of food they liked and that met their preferences.

People were not supported to have maximum choice and control of their lives and staff did not supported them in the least restrictive way possible. The provider's policies and systems in relation to the Mental

Capacity Act and Deprivation of Liberty Safeguards (DoLS) were not followed. Assessments of people's capacity to make decisions had not always been completed when they were needed. Information was not available to people in a way their understood to help them make decisions and choices, including communication tools recommended by healthcare professionals. The registered persons did not fully understand their responsibilities under DoLS and authorisations had not been applied for when there was a risk that people may be deprived of their liberty.

Staff had not been recruited safely and checks had not been completed to make sure they had the skills knowledge and experience they needed to fulfil their role. Disclosure and Barring Service (DBS) criminal records checks had been completed. Staff were not supported meet people's needs and had not completed the training they needed to fulfil their role when they began working at the service.

Some parts of the service were not clean and staff did not always follow infection control processes to protect people from the risk of infection. The building was not well maintained in all areas and shortfalls were not addressed quickly. People were able to use all areas of the building and grounds and were encouraged to make their bedroom feel homely.

The registered persons had not informed CQC about all the significant events that had happened at the service, so we could check that appropriate action had been taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff had not always identified and reported safeguarding concerns.

People were not always protected from risks.

Staff were not always recruited safely.

Staff had not been deployed to meet people's needs and preferences.

People's medicines were not always stored safely.

People were not always protected from the spread of infection.

Is the service effective?

Inadequate

The service was not effective.

People's needs were not assessed.

Staff were not supported to provide effective care.

Applications for Deprivation of Liberty Safeguards had not always been submitted when people's liberty was restricted.

Some areas of the service had not been maintained.

Guidance had not always been provided to staff about the support people needed to manage their healthcare needs.

Staff had made referrals to healthcare professionals when people's needs had changed.

People were supported to eat and drink safely.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always refer to people in a respectful manner.

People were not supported to be as independent as possible.

People were not always supported to communicate their needs and preferences.

People did not always have privacy.

Is the service responsive?

Inadequate

The service was not responsive.

People and their relatives were not supported to plan their care and support.

People were not supported to develop their independence and learn new skills.

People were not always supported to take part in pastimes they enjoyed.

Complaints were not managed as the provider required.

People had not been supported to plan their care in the way they preferred at the end of their life.

Is the service well-led?

Inadequate

The service was not well-led.

The provider lacked oversight the service and had not ensured it was led by a registered manager with the necessary skills and knowledge to carry out the role.

The provider had failed to notify us of important events that happened within the service.

Checks and audits had not identified shortfalls highlighted at this inspection.

People, their relatives and others had not been asked for their views on the service.

Grove Villa Care

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 23 and 24 July 2018 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed information, we held about the service. We used information the provider sent us in an action plan. We also reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like a serious injury. We contacted eight health and social care professionals who have had recent involvement with the service for their views and received four responses.

We asked the provider to send us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We inspected the service before the deadline for the PIR to be submitted had passed.

During our inspection we spoke with two people, six people's relatives, two visiting health care professionals, the registered provider and seven staff. We looked at care records and associated risk assessments for five people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received. We looked at their medicines records for five people and observed people receiving their medicines.

Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Most people's relatives and health and social care professionals told us they did not have any concerns about people's safety at the service. However, we found that people were not safe living at Grove Villa Care.

People were not protected from the risk of abuse and were not protected from harm. Three people had sustained injuries at the service. Two people had been hit by another person and one had bruises which were unexplained. The registered persons had not taken action to investigate these incidents and prevent them from happening again. Staff had not recognised that these incidents were potentially abusive and taken action to protect people in the future. The deputy manager told us in relation to the unexplained bruises, "It's ridiculous no action was taken as it was clearly a safeguarding matter". The registered persons had not reported the incident to the local authority safeguarding team so they could investigate the concerns and provide support to the staff team about the prevention of further incidents. We found similar shortfalls in April 2017 and improvements made at our last inspection had not been maintained.

Robust systems were not in place to safeguard people's money. Prior to this inspection the provider had been notified by the local authority regarding allegations of financial abuse. The provider told us they had not investigated this as they did not believe the allegations. There was a system in place to obtain and check receipts for money people spent. This was not followed by staff. We checked three people's personal allowance against records and receipts. We found that receipts for two people totalling £7 and £12 could not be found to confirm that money had been spent on their behalf. The deputy manager told us, "I immediately saw that the system was a complete muddle and I had planned to get around to doing it. But there's so much here in a complete muddle and what do you do first".

The registered persons had failed to protect people from abuse. This had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of unsafe care. At our previous two inspections, risks relating to people's care and support had not been adequately assessed and guidance for staff did not contain the level of detail necessary to keep people safe.

There was a risk that people living with epilepsy would not receive the care and treatment they needed when they had a seizure. At our last inspection we found that guidance was not in place about how to keep one person safe if they had a seizure. At this inspection we found that although guidance was in place it was contradictory. One person's needs had changed. Interim guidelines from their GP included the use of emergency medicine, however their epilepsy care plan stated they did not have guidelines for emergency medicine. The person had seen their specialist epilepsy nurse in April 2018 and they had agreed to send detailed guidelines about the use of the emergency medicine. These guidelines were not in the person's records and staff did not know if they had been received. Some staff we spoke with did not know what type of seizures the person had or if they were prescribed emergency medicine.

Incidents of behaviour that challenged were not consistently recorded so they could be analysed to look for

trends and patterns and ways of reducing them happening again. At our last inspection we found that incidents had been recorded and collated but staff had failed to identify some consistent triggers. During this inspection we found that incidents were not always recorded. For example, we observed one person became distressed at lunchtime and this was not reported. People did not receive consistent support to manage any behaviour that challenged. One person's relative described to us an incident they had seen when their relative hit another person. They told us, "It really hurt [person's name], who looked upset. They rubbed their arm for a long time afterwards and must have had a bruise as anyone would have".

Some staff had received training in 'managing challenging behaviour', other staff had not. Some people's care plans included guidance for staff about potential triggers for people's behaviours and how to respond. During the inspection some people became distressed and staff tried to distract and divert them. We asked one staff member how they knew what action to take when a person became distressed. They told us they copied what they had seen other staff doing to calm the person. We asked the staff member if they had received training in behaviour that challenged and read the guidance about the support the person needed. They told us they had not.

Some people used bed rails to prevent them from falling out of bed. Risk associated with the use of bed rails, such as the risk of injury or entrapment, had not been assessed to in accordance with the provider's policy. For example, on one person's bed there was a gap between the bedrails and the wall at the head of the person's bed large enough for them to fit their head or limbs into and there was a risk that they would have become trapped in the gap and sustained an injury.

Guidance had not been provided to staff about the safe use of pressure relieving equipment. Some people used special mattresses to reduce the risk of them developing pressure ulcers. One person's mattress was set at 140 kg, approximately 22 stone. The person had not been weighed and staff did not know how much they weighed. Guidance had not been provided to staff about how to use their pressure relieving mattress so that the person received the maximum benefit from it. Lying on a mattress that was too soft or too firm may not have given the person the best protection from developing skin damage.

People were not protected from the risks associated with fire. There were personal emergency evacuation plans in place for each person. One person's plan did not include a plan to support the person to evacuate the premises in an emergency if they were in bed. People and staff had not taken part in regular fire drills to practice what they needed to do to keep safe. The actions staff told us they would take in a fire were contradictory, including where they would evacuate to outside the building. Staff's comments included, "It would be all hands to the deck and get everyone out, whoosh as quickly as possible" and "I suppose we would all rush around until everyone was out". Records of all the checks completed on the fire safety system by a fire safety contractor were not available at the inspection and the registered person was not able to tell us when these checks were last completed. We shared our concerns with Kent Fire and Rescue Service after our inspection and they visited the service.

The registered persons had failed to ensure that staff had the necessary guidance to keep people safe. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action had been taken to protect people from the risk of choking. Since our last inspection people's care plans had been updated with the actions staff must take if people choked. This included how to support people who used a wheelchair. A speech and language therapist had worked with staff to develop their skills and knowledge of people's individual needs and their guidance was available for staff to refer to.

Risks to people using the kitchen had been mitigated since our last inspection. The equipment had been moved around to keep high risk equipment away from food and drink preparation areas that people used regularly. During our inspection we observed some people making drinks and snacks independently and one person did the washing up.

People were not protected by the safe management of medicines. Medicines were not stored safely. Guidance from the Royal Pharmaceutical Society of Great Britain to store medicines below 25°C, had not been followed. Two staff told us the temperature of the medicines room was a longstanding concern. One staff member said, "I have asked for air conditioning many times as you come out of the room running in sweat". The weather had been very warm for several weeks and during our inspection medicines were stored at 29°C and 32°C. Two of the medicines stored in the room needed to be stored below 25°C to ensure they remained effective this include medicines prescribed for the management of epilepsy. The provider took remedial action to reduce the temperature following our inspection and we will check that this has been effective at our next inspection.

One person was not receiving their medicine as prescribed by their doctor as staff felt it was not always needed. A staff member told us this arrangement, "had carried on for many months". The medicine had not been administered for 9 days in July 2018. Guidance had not been given to staff about when to withhold the medicine and staff followed different practices. One staff member told us, "I usually don't give it unless carers tell me there's a need for it". Another staff member said, "I tend to go to give it unless staff have found …. [the person] doesn't need it". The first staff member commented, "The arrangement could result in inconsistency and really should have been checked out with the doctor first". However, the person's GP had not been made aware of the practice and asked for advice.

There was a risk that people would not receive their 'when required' medicines when they needed them. One person was prescribed pain relief but staff did not know what might cause the person's pain. Guidance had not been provided to staff about the administration including what it was used for, the maximum dose each day and other medicines it should not be taken with. We discussed the dose with two staff who administered the medicine. One staff member told us, "perhaps two or three like paracetamol". The second staff member said, "One a day and not just one at a time". Taking too much of the medicine or taking it with other pain relief medicine which contained the same medicines could make the person seriously unwell.

The registered persons had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were suitable arrangements in operation for ordering, stock checking and disposing of medicines. Staff observed people taking their medicines and recorded the administration accurately.

People were not supported by staff who had been recruited safely. At our last inspection we found that provider's recruitment policy had not been followed, gaps in employment history had not been explored and suitable references had not been obtained. Since our last inspection the registered persons had not acted to ensure staff were always recruited safely and continued not to follow the provider's recruitment policy.

The Providers had recruited a new manager who was due to begin working at the service in September 2018. The Provider told us they had interviewed the manager with their Care Consultant and "robust process had been followed". References had not been obtained for the manager and gaps in their employment history had not been explored. Despite the new manager not having an official start date of September 2018 at the time of our inspection they had begun working at the service at the weekends to familiarise themselves with

the service and the provider's processes.

We looked at the employment records for one new staff member who was working alone with people. An application form, including their qualifications and experience, a full employment history and referees had not been completed. Checks on their conduct in previous employment working with vulnerable people had not been undertaken and any gaps in their employment history had not been identified and explored. A reference had been obtained from a former employee at the service who had left three days before our inspection.

The provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Criminal record checks with the Disclosure and Barring Service (DBS) were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people.

There were not enough staff on duty to ensure people received safe care. On the first day of our inspection 3 staff were on shift until 2pm. From 2pm until 9pm 2 staff were on shift. A new staff member had started that day. They had not completed any induction and were working alone with people. One staff member on each shift was taken off caring duties in order to prepare, cook and serve meals. The provider told us that staff rotas were not accurate. They were unable to confirm what the accurate staffing levels were. Since our last inspection the registered persons had failed to maintain the improvements to staff deployment we noted at the last inspection. Staff told us, "It can be tight not for the provision of physical assistance but because it limits the activities people can do as they all need help to go out and also limits one to one time so people do spend a lot of time on their own" and "Most shifts are filled but even then, it can be hard to give people individual attention and certainly it does limit the amount of personal help people get with activities". No system was in operation to determine how many staff were needed to meet people's needs at different times of the day and the provider told us the process was "an informal basis only". One to one support had been purchased for some people by the local authority. The provider did not know what had been purchased for each person and told us, "In any case we don't have the staff available to give planned one to one and so the hours do have to be shared".

Shortly before our inspection the provider had employed agency staff to support people at night. There was no process in operation to make sure that agency staff had information about people and the providers systems. Agency staff worked alone with people at night which increased the risk that people would not receive the support they needed as agency staff did not know them.

Although staff were allocated tasks at the beginning of the shift they were not deployed when people needed them. At lunchtime one person was supported to eat safely by staff. During their meal another person required support as they had become upset. The staff member left the person to in the middle of their meal, to support the other person. The first person sat at the table looking at their meal which was out of their reach. A third person who also required support sat alone away from the dining tables and watched other people eating their meal for 30 minutes without any staff interaction.

The registered manager was not present during our inspection. The service was being managed by a new deputy who was supported by the provider. The deputy manager and the provider were not able to easily and quickly give us a lot of the information we requested during our inspection. The provider told us, "I'm in charge of the service but don't have any of the information I need to run it".

The registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service was not clean and people were not protected from the risk of infection. The provider told us the service was "spotlessly clean" and that "no other action needs to be taken on that score". However, we found this to be incorrect and the provider's cleaning policy had not been followed. For example, on the first day of our inspection there was no toilet paper in one toilet people used during the day and at night. We told the provider about this. We checked the toilet at 10.00 and 15.30 the following day and found that again no toilet paper was available to people.

Some people needed support to manage their continence. One person's bedroom smelt strongly of urine. Staff agreed that the room was odorous and one described it as "dire and overwhelming". The person had a mattress which could be easily cleaned but systems were not in operation to clean the room and furnishing regularly. The cleaner told us they did not have a cleaning plan to follow, as required by the provider's policy, but tried "to get around to most parts of the place every week". Records of what had been cleaned and when were not maintained.

A check of the environment had identified that a toilet was not flushing in June 2018. Action had not been taken to repair the toilet and on the first day of our inspection we found that it continued to be used and was full of excrement. We told the provider about this and they told us the toilet would be cleared immediately and repaired. On the second day of our inspection we found that the provider had not taken effective action to clean and repair the toilet. The toilet seat had been taped over, the room smelt strongly of urine and faeces and the risk to people continued.

The service had been given a food hygiene rating of four (Good) by the local authority in July 2017. The provider was not able to show us a copy of the local authority's report or explain what improvements were required to achieve a very better rating. The provider told us that all the required food hygiene checks were "completely up to date". We asked to see copies of the records but the provider did not give them to us. Two staff we spoke with who supported people to make food and drinks told us they did not know that records of cleaning and the temperature of food and equipment temperatures should be maintained. Neither staff were able to give us a good account of how they would manage the risk of cross contamination.

The registered persons had failed to ensure that the premises and equipment used by service users were clean. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service effective?

Our findings

No one new had moved into the service since our last inspection and there was one vacancy. The local authority had referred one person to the service shortly before our inspection. We asked the registered provider and the deputy manager how they would make sure they could meet the person's needs in the way they preferred. Neither of them were able to describe the provider's process to us. The provider's process did not require staff to always met with the person and their representatives before they offered the person a service and a needs assessment tool was not provided. This reduced staff's ability to gather all the information they needed to be confident that they can meet the person's needs in the way they preferred.

Following our inspection, we took urgent enforcement action against the provider and applied a condition to their registration stopping them admitting anyone new into the service without our prior agreement. This was to prevent anyone further being put at risk at the service.

People did not receive consistent support to manage their healthcare needs. One person had frequently checks at the dentist to monitor an oral health condition. Although guidance from the dentist had been recorded it had not been followed by staff. In June 2018 the dentist had recommended that the person brush their teeth more frequently and use an electric toothbrush and 'special' toothpaste. The person did not have an electric toothbrush or the suggested toothpaste. We asked staff why the person did not have these items. They told us they did not know. The person had loose teeth and had had teeth removed. There was a risk that the person would have further tooth loss if they were not supported to follow the guidance from their dentist.

People's risk of losing weight was not monitored so action could be taken to keep them as healthy as possible. Assessments of the risk of some people not eating enough to remain healthy had been completed but any required action had not been noted. People were weighed regularly, however equipment was not available to make sure that everyone could be weighed accurate. Some people used walking aids and were weighed while using their aids. We asked staff how they could be assured that the reading was accurate. They told us they could not. Records showed that the weights of people who used walking aids varied dramatically from month to month. For example, one person weighed 6st 8lbs in May 2018 and 8st 1lb in June 2018. Staff told us the person had not put on a significant amount of weight in the month. No analysis of people's weights had been completed to identify the risks of people becoming malnourished. One person had a goal to reduce their body mass index (BMI). The person had not been weighed and staff did not know what their weight or BMI were. Plans were not in place to support the person to eat a reducing diet.

The registered persons had failed to design care with a view to achieving service users' preferences and ensuring their needs were met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person was unwell during the inspection and the provider took them to the hospital. A physiotherapist we spoke with told us staff had referred a person told them correctly when they noticed a change in their mobility.

Staff continued to lack a suitable understanding regarding best practice when working with people with learning disabilities. At our last inspection we found that although staff had completed training in person-centred care and challenging behaviour, they did not have any knowledge regarding person-centred planning (a way of helping a person to plan their life) and person-centred active support (a way of supporting people to be as independent as possible.) At this inspection we found that people's care and support continued not to be planned and delivered in line with best practice. The provider told us, "There's a well organised system of staff training and all of the staff know what they're doing". We found this was not the case.

We looked how three new staff had been supported to get to know people, their care and support needs and to understand their roles and responsibilities when they started working at the service. Records were not clear about what induction process had been followed and when staff had been assessed as competent to complete their role. The deputy manager told us, "It's just chaos really, plain and simple. With no clear system for induction training and no consistent records. It needs a complete overhaul". New staff members we spoke with were not able to tell us about how they would identify common changes in someone's health, including how they would know that a person was dehydrated.

The provider's staff training and development policy required all new staff to complete the Care Certificate with 12 weeks of beginning work at the service. The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life. New staff we spoke with had not enrolled onto the care certificate and did not know this was part of their induction training. There was a continued risk that people would not receive the support they needed because new staff did not have the required skills and knowledge.

Staff continued to lack a suitable understanding regarding best practice when working with people with learning disabilities. At our last inspection we found that although staff had completed training in person-centred care and challenging behaviour, they did not have any knowledge regarding person-centred planning (a way of helping a person to plan their life) and person-centred active support (a way of supporting people to be as independent as possible.) At this inspection we found that people's care and support continued not to be planned and delivered in line with best practice.

Previously we found that staff had Staff received regular one to one supervision from a senior member of staff to discuss their performance and personal development. However due to the lack of knowledge of senior staff supervising them they did not always provide person-centred care. At this inspection we asked the provider to show us records of staff supervisions. The provider and deputy manager told us they were not able to find supervision records to show us. Two senior care staff we spoke with told us it was their responsibility to supervise care staff but that staff supervisions were overdue. The senior are staff also told us that they had not received supervision for over three months. One staff member told us, "The last one was sometime never".

The provider's training and development policy stated; 'All staff have an annual appraisal in which the outcomes from any training the staff member has had and their future needs are discussed'. Staff had not received an annual appraisal as the provider required.

The registered persons had failed to ensure staff were appropriately trained and competent to carry out their roles. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Mealtimes at Grove Villa were not a positive experience for people. We observed at one lunchtime that meals

time was chaotic and people did not receive the support they required. Despite seven people requiring individual staff support to eat their meal, only one staff member was working in the dining room with them. Two people needed individual support from a staff member dedicated to helping them. Other people needed staff to supervise them closely to reduce the risk of them choking. We observed one person who had not received their meal get up from a table where other people were eating their meal three times in twenty minutes and go and look into the kitchen.

Staff used a picture board to help people choose between food items. Staff had spoken to one person about what they wanted for lunch and the person had said a sandwich. Another staff member used the picture board to ask the person what they wanted to eat. The person pointed to sausages, peas and chips. The person was served the meal at lunchtime and ate it all. Another person liked their breakfast prepared in the same way each morning. We observed that they breakfast was prepared as they preferred on both days of our inspection.

Staff followed guidance from a Speech and Language Therapist about how to prepare meals of people who were at risk of choking. This included soft and pureed foods which people could swallow easily.

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 application 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.

People's care had not been planned to make sure any restrictions were kept to a minimum if they had a DoLS authorisation in place. This was because the system for applying and implementing DOLs authorisations was not reliable and robust. Information about DoLS was not included in people's care plans and the provider and deputy manager were not able to tell us if DoLS authorisations were in place for some people. During the inspection the deputy manager found information which showed that one person's authorisation had expired and an application for another DoLS had not been submitted. The outcome of another person's assessment in January 2018 was not known.

People's ability to make important decisions had not been assessed and people had not been supported to make decision in ways they preferred, in accordance with the provider's policies. For example, 'written consent' had not been obtained from people agreeing the use of bedrails. Assessments of people's capacity to agree to the use of rails had not been completed. Decisions had not been made in people's best interest by people who knew them well when people lacked the capacity to make the decision.

The registered persons had failed to act in accordance with the Mental Capacity Act 2005 and their own mental capacity policy to obtain lawful consent to care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some areas of the building and furnishings had not been fully maintained to ensure people were safe and comfortable. On the first day of our inspection we found that the alarm fitted to the fire escape door on their first floor was not working. The door led out onto a fire escape staircase which led to the garden and to the

street. Fourteen of the 15 people lacked capacity to understand the risk of leaving unsupported and needed assistance when in the community. The provider told us the alarm needed to be repaired "straight away". We checked the alarm the following day and found that it was still not working. Checks were completed on the environment which the provider told us were a "comprehensive assessment of all things that needed attending to" and told us that all the shortfalls noted for action in June 2018 had been completed. We found that the actions had not been completed and two people continued not to have curtains at their bedroom windows. We also found that one person did not have a light shade in their bedroom and their mattress was badly stained.

People were not fully involved in planning how their bedrooms were decorated. We viewed people's bedrooms which contained personal items. However, one person had been requesting since December 2017 that their bedroom be redecorated. The provider was not aware of this and no action had been taken to redecorate the person's room. One person's relative described the service as 'rough and ready'. The service was accessible and corridors were wide, so people were able to mobilise using a wheelchair with ease.

Inadequate

Is the service caring?

Our findings

People continued not to receive care and support in the way they preferred. At our last two inspections we found that people were not always treated with dignity and respect. This continued. Previously we found that people were not referred to in respectful ways in their care records. At this inspection we found that people were described as 'very impatient', and not 'complying' with or 'tolerating' medical checks. Again, no consideration had been given to these potentially disrespectful descriptions and the registered manager and provider had not ensure they were removed from people's records.

One person told us about a close relative who was important to them. They told us their relative was coming to see them and showed us pictures of them. The person's records contained information indicating that the person's relative have passed away but other areas of their care plan did not. We asked the deputy manager if the person's relative had passed away. They told us they did not know. There was a risk that the person would be given inaccurate information about their relative which would cause them confusion or distress.

One person's relative told us, that although the staff were kind, they did not notice 'basic things' which had an impact on their loved one. For example, the person did not have a belt or braces on their trousers for a long time and their trousers kept falling down and one pair of their shoes needed to be repaired.

Some people were isolated and staff did not have time to spend with them. We observed one person sitting alone in the lounge. A staff member walked into the lounge and the person got up and approached them, holding their hands out. The staff member held the person's hand and said hello and then walked away. The person sat back down on their own. No staff engaged with the person for 45 minutes and they sat alone watching other people and staff engaging in the lounge.

We observed the same person at lunchtime. The person was not supported to sit at the table with other people to eat their meal. The person sat on a sofa watching other people eating their meal for over 30 minutes. Once other people had finished their meal a staff member sat with the person at a table on their own and supported them to eat their meal. The staff member did not chat or engage with the person and they were not told what they were eating or asked if they were enjoying it.

We observed some kind and caring interactions from staff when people became distressed and staff tried to calm them and reduce the risk of them becoming more upset. One person became distressed several times and staff went over to them and offered them reassurance. They bent down and spoke to the person at their eye level. They asked the person if they needed anything and gave them the things they requested. However other people who did not initiate interactions with staff or have behaviours that challenged staff did not receive the same level of engagement from staff.

People did not always have privacy. For example, health care professionals planned to visit the service to speak with staff about one person. The letter from the health care professional including their name and the reasons for the visit was displayed on a noticeboard in the hall way and was visible to people and visitors to the service.

The registered persons had failed to ensure people were treated with respect and dignity. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From April 2016 all organisations that provide NHS or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. The provider was not meeting the Accessible Information Standard and the support people received to communicate had reduced since our last inspection and people had less opportunities to make their needs and wishes known. At our last inspection staff used a board with pictures of objects to assist some people to communicate their needs and choices and this had increased people's opportunities to make their needs known. At this inspection staff had stopped using the board except to ask people to choose what they wanted to eat mealtimes and told us they were waiting for guidance from the speech and language therapist team. One person had a set of 'chatty cards' to help them tell staff about their wishes but they were not encouraged to use them. We spoke with a speech and language therapist who confirmed everyone using the service had been referred to their team and were on the waiting list. They also told us that there was "Not a lot in place about people's communication" and the staff needed more support to develop their skills.

The registered persons had failed continually to ensure people received person-centred support regarding their communication needs. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people needed additional support from an advocate and this was arranged by their case manager, usually as part of their Deprivation of Liberty Safeguards. An advocate is an independent person who can help people express their needs and wishes, weigh up and make decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. We received feedback about the service from one advocate before our inspection. They told us, 'All contact between the staff and the residents that I have witnessed has been kind and respectful, and in view of the fact that many of the residents have communication difficulties, I have always been impressed by their ability to understand or interpret the residents'. Other people were supported to their relatives or local authority case manager.

Inadequate

Is the service responsive?

Our findings

People continued not to receive person centred care and their care was not reviewed. People were not supported to set and achieve goals and become more independent. For example, making and drinking hot drinks was very important to one person. The person was a risk of scalding when using a conventional kettle so the provider had purchased a 'one cup' kettle to support the person to make themselves a hot drink safely. However, the person had not been supported to learn how to use the one touch kettle and continued to rely on staff to make drinks for them.

Another person's goals stated that they wanted to go swimming regularly. We asked staff how often the person went swimming. Staff member told us the person had not been swimming for at least three years and they did not know why.

Although people were involved in making decisions about what they wanted to eat and drink, action had not been taken since our last inspection to support some people to take part in food preparation. People who were able to prepare drinks and snacks without support did so in the kitchen. Other people were not supported and encouraged to be involved in preparing their own meals. One person's care plan described how they did not appear to be able to prepare their own food and they had not been offered the opportunity to develop these skills.

We looked at five people's care records. Although some areas of the records were written in an accessible way, including pictures, people had not been involved in planning their care and support with staff. People and their relatives told us they wanted to be involved in planning and reviewing people's care but had not always been involved to make sure it met their needs. One person's relative told us they were annoyed that they had not been invited to attend their loved one's annual review. They told us it was important that they attend as their loved one required an advocate as they lacked capacity to make some decisions and were "very suggestible and will agree to pretty much anything".

The provider and deputy manager had different views on how frequently care plans should be reviewed. The provider told us they should be reviewed "monthly" and the deputy manager said, "six monthly". They then said, "It must be monthly then". Records of care plans checks showed that reviews of care plans had not taken place. We asked the provider what action had been taken to make sure that reviews were completed as the required. The provider replied, "I don't know, I can't tell you, what else can I say".

Some people's relatives told us they their loved ones were not supported to take part in regular activities at the service or in the community. One relative told us their loved one spent a lot of their time without anything apparent to do. We found that this was correct and people were not regularly given the opportunity to take part in hobbies and interests they enjoyed. People did not have individual daily activity plans, which they had been involved in developing with others who knew them well when necessary. At our last two inspections we found that staff had not followed guidance provided a speech and language therapy (SALT) in April 2016 to 'implement visual day planning' with one person. The aim of this was to ease the person's anxiety around going out and helped staff to plan with the person their activities for the day. At this

inspection we found that staff had still not implemented the visual day plan for the person. The deputy manager and provider did not know why this had not been done. We spoke with the person's speech and language therapist who was not aware that their recommendation had not been followed. The person's day did not have structure and they spent long periods of time sat in the same place not engaged with staff or in an activity. We observed the person display behaviours that challenged staff several times during our inspection.

People, with support from their relatives, had not been encouraged to discuss and share their end of their life care and treatment preferences. At our last inspection we found that some people had a plan in place regarding what they wanted to happen when they died, however this had not been put in place for everyone. The registered manager told us this was an area for improvement. At this inspection we found that the provider's advanced care planning process had not been followed and no improvements had been made. We would expect staff to have asked people about their preferences including any cultural or spiritual needs, where they preferred to be and who they wanted with them. This information is important to enable staff to provide people's care and treatment in the way they want, when the time comes.

The registered persons had continually failed to design, with service users and their representatives, care which met their needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported to raise any complaints or concerns they had about the service. At our last inspection we found that an easy to read version of the provider's complaints process was displayed at the service. At this inspection we found that any easy read version was no longer displayed. The provider's full complaints process was displayed and the deputy manager told us, "It's silly to pretend that this is a meaningful procedure as none of the residents are able to understand the written word in long sentences like that". A suitable easy read version had been designed, however plans were not in place to meet with each person to make sure they understood it.

People we spoke with told us they would raise any concerns they had with their family members. We looked at records of complaints which were stored in two separate records. These showed that two complaints had been received from family members since our last inspection. Some action had been recorded in response to one complaint but there was no record of a response to the complainant and if they were satisfied with the action taken. The second complaint record showed that there was a difference of opinion between the complainant and the service about an issue. However, records did not show how this had been resolved. The deputy manager told us they had not read the provider's complaint policy and did not know what it required. The provider's complaint process had not been followed with regards to these two complaints. On reviewing the complaint records with us the deputy manager told us, "Really there isn't a system for dealing with complaints and we need to get that sorted too".

Staff continued to hold regular resident's meetings with people, and asked them if there was anything they would like to change, however, some people had complex needs and were unable to communicate verbally. Due to lack of effective systems in operation at the service to support people with profound needs to communicate their needs and wishes, there continued to be a risk that the signs that people were unhappy with their care would be missed.

The registered persons had failed to effectively operate an accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well led. At our inspection April 2017 we found that the provider lacked oversight of the service and the registered manager lacked the skills and knowledge to carry out their role effectively. There were multiple breaches of the Health and Social Care Act and we issued a warning notice relating to safe care and treatment. We also placed a condition on the provider's registration, requiring them to send us monthly updates on the service. These have not been received as required.

At our inspection in January 2018 we found that action had not been taken to address the shortfalls and there were continued breaches of the Health and Social Care Act 2008 related to safe care and treatment, person centred care and governance. Following this inspection, we took further regulatory action against the provider. Full information about the Care Quality Commission's (CQC) regulatory response to the serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The required improvements had not been made to the service and care was not planned and delivered to meet people's individual needs and preferences. Following our last inspection, the provider employed a consultant to help them make the necessary improvements to the service. An improvement plan had been drawn up, however action had not been planned to quickly improve the service. For example, the action plan stated, 'A complete review of all care plans will be carried out to ensure that service users are fully supported with all their needs especially healthcare'. This review had not begun at the time of our inspection despite the provider's deadline for completion for people with 'High Needs' being July 2018. The provider told us, "[The consultant] has told me things are well on course to being sorted and this will show in the next CQC inspection".

Previously, we found that there was no sense of leadership and direction at the service. At this inspection we found that this continued, the former deputy manager had left the service three days before our inspection and the registered manager was working their notice. The registered manager was not working at the service during our inspection. A new deputy manager had been employed and was working at the service, the first day of our inspection was their first day working alone without support from the former deputy manager. Only one partner from the provider organisation had any involvement in the day to day in running of the service and they were at the service during our inspection. The provider told us, "This is the worst time for the inspection as the new manager isn't in post and I don't know enough to tell you about the changes but they've been made for sure".

The provider had recruited a new manager subject to references who had experience of managing services and they were due to begin working at the service in September 2018. The deputy manager did not know people and their needs well. They were on call all the time they were not on site and it was their responsibility to support staff if they needed advice and guidance about people's care and treatment needs. There was a risk that staff would not receive the information and guidance they required to keep people safe and well, as the deputy manager did not know people well.

The registered persons continued not have oversight of the service. Previously, we found that the provider was not able to access important information in the absence of the registered manager. At this inspection the provider was not able to answer many of our questions. They told us, "This [the registered manager not being present] has left me high and dry, I'm in charge of the service but don't have any of the information I need to run it". We asked the provider why they had not notified us when they had received information of a safeguarding nature about a staff member. They told us, "I'm not that sure what I need to tell CQC about and that's why I have professional managers working for me. The last one has let me down and that's why we're here where we are today".

Checks and audits had not been completed as the provider planned. The provider told us that checks and audits were, "now sorted after [the consultant's] involvement and were up to date". The deputy manager told us that a schedule of audits was in place but had not been fully implemented. For example, the audit plan required monthly care plan checks. The deputy manager told us these had just restarted after "at least three months".

The provider and deputy manager did not know how the new care plan audit should be completed and there was a risk that it would not be completed or interpreted correctly. The audit tool used a 'RAG' rating, defined as 'level of need'. The provider and the deputy manager had different opinions on what this meant. The provider told us it was, "To indicate complexity of care needs", while the deputy manager said it meant, "Whether additional work needed to be done to meet the person's needs". The deputy manager then commented, "We're not even clear on that are we?".

Checks completed had not been effective and shortfalls we found during our inspection had not been identified. For example, we looked at a medicines audit which the deputy manager understood to be the most recent one but they told us they could not be sure as the date of completion had been crossed out. One of the questions read, 'Are temperature conditions in the storage area appropriate?'. The answer 'Yes' had been ticked. A comment had been recorded in another part of the audit stating, 'Could be more robust and needs to be updated and signed by the doctor', but there was no information about what the shortfall was. The provider and registered person told us they did not know what the comment referred to or if the action had been taken.

Up until April 2018 the registered manager had completed 'bimonthly managers reports', which covered issues such as care plans being up to date, fire checks being current and incident management. The provider told us they used to see these reports and had discussed them being overdue with the registered manager but had not taken the matter further. The report dated 25/04/2018 had not recommended any actions be taken.

The service continued not to be delivered in accordance with the provider's mission statement, which noted, 'Our ethos has always been to provide a high standard of service but also to create a homely atmosphere where the service users feel comfortable, respected, empowered and happy, regardless of their disability'. At our previous two inspection we found that staff did things for people, rather than with them. Some of the improvements noted at our last inspection, such as the use of a picture board to help people choose between two different activities had not continued and people continued not to be supported to be independent and achieve their goals.

The provider and staff did not have access to the information they needed to provide a safe service to people, as records about all areas of the service including people's needs were inaccurate and incomplete. For example, one person's records contained contradictory information about their oral care needs. Their health care plan stated that they should brush their teeth three times daily. Their recorded goal was to brush

their teeth twice daily. Staff were not able to tell us how often the person should be supported to brush their teeth each day.

The duty roster we viewed was inaccurate and did not contain the details of all the staff who had worked at the service. The provider told us, "I accept that the roster isn't anything like an accurate or complete record because it looks like we only had two care staff and one senior on Saturday and no sleep night on either day".

People continued to meet each month and discuss their views and ideas about areas of their service including the meals and activities but their views were not consistently acted on. Records of the meetings showed that one person had asked in several times since December 2017 for their bedroom to be redecorated. The provider told us they were not aware of the person's requested. The person's bedroom had not been decorated.

People, their relatives and other stakeholders had not been asked for their views of the service each year as the provider's Quality Assurance Monitoring and Reviewing the Service Provision Policy required. A questionnaire had been sent to ten people's relatives, a member of the local authority safeguard team and a doctor shortly before our inspection. The deputy manager told us they did not know why everyone's relatives and other people involved in people's care, such as speech and language therapists and case managers had not been asked for their views. Some responses had been received but had not been reviewed to identify any areas for improvement. We asked the provider when the last survey was done and what action had been taken in response to it. They told us, "In the past some time ago and I don't know what they said". They were not able to show us records of the previous survey when we requested them.

The registered persons had continually failed to operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The registered persons had failed to make suitable arrangements to respect and involve service users and had failed to maintain accurate and complete records. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered persons did not truly understand their responsibilities with regards to running a regulated service. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This ensures that CQC can then check that appropriate action had been taken. At our previous inspections the registered persons had failed to notify us of important events including the authorisation of DoLS applications and potential incidents of abuse. At this inspection we found that we had not been notified of a potential safeguarding incident between two people living at the service and allegations about a staff member.

The registered persons had failed to notify CQC of notifiable events in a timely manner. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Local authority and health staff had worked with the provider to try to bring about improvements. The safeguarding co-ordinator had visited the service and met with the provider and a speech and language therapist was due to visit the service to give all the staff information about one person's needs. The safeguarding co-ordinator told us, 'They have a better understanding of the importance of having strong effective leadership and realised that this had been lacking through inexperience of the previous manager who did not have the depth of knowledge to put into action the plan. I feel confident that they have an increased awareness of safeguarding and how the issues of vulnerabilities of the service users can lead to risk of harm'.

The local commissioning team continued to visit the service regularly and were monitoring the service and working with them to try and bring about improvements. For example, discussions had been held about how the provider could obtain the expert advice and guidance they needed to improve communication for people. These had not been put into action at the time of our inspection.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall. The provider did not have a website.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons had failed to design care with a view to achieving service users' preferences and ensuring their needs were met. The registered persons had failed continually to ensure people received person-centred support regarding their communication needs. The registered persons had continually failed to design, with service users and their representatives, care which met their needs and preferences.

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons had failed to act in accordance with the Mental Capacity Act 2005 and their own mental capacity policy to obtain lawful consent to care and treatment.

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had continually failed to ensure that staff had the necessary guidance to keep people safe. The registered persons had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons had failed to protect people from abuse.

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons had failed to ensure that the premises and equipment used by service users were clean.

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered persons had failed to effectively operate an accessible system for identifying, receiving, recording, handling and responding to complaints.

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had continually failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively.

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to deploy

sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs.

The registered persons had failed to ensure staff were appropriately trained and competent to carry out their roles.

The enforcement action we took:

We cancelled the provider's registration to provide accommodation to people who require personal care.