Hartford Care (Southern) Limited

The Laurels and Pine Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 unannounced comprehensive inspection took place on 15 and 17 August 2018, with a brief visit to the service on 21 August 2018 to clarify issues discussed at initial feedback on 17 August and to check what action the service had taken.

The Laurels and Pine Lodge 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.

The Laurels and Pine Lodge accommodates up to 55 older people across two wings of a converted building, each of which have separate adapted facilities. One of the wings, Pine Lodge, specialises in providing care to people who live with dementia. At the time of the inspection, around 45 people were living or staying at the service.

The two units were overseen by one registered manager. 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.

The service had an open and friendly feel. People commented positively on the atmosphere, for example, "To my way of looking at it the home is well led. It is a very nice home to be a resident in." The registered manager sought to operate an 'open door' policy and during the inspection spent much time on the floor with people and staff, who responded as if this was a regular occurrence. Open communication was promoted through daily '10 at 10' meetings between senior staff from all departments. Staff received updates through handovers, supervision and staff meetings.

People were treated with kindness, respect and compassion. Care staff and managers knew and cared about people who used the service. Staff respected people's privacy and promoted their dignity. There were many positive interactions, while staff supported people and as they were passing by. Staff were attentive, noticing when people looked uncomfortable or upset. They quickly offered the care and support needed.

People received care that met their individual needs. Wherever possible, staff promoted people's independence. Care was planned and delivered based on people's individually assessed needs and preferences. People consented to their care, or if they lacked the mental capacity to do so, care was provided in their best interests in line with the Mental Capacity Act 2005. Assessments and care plans were reviewed and updated regularly, with the involvement of people and their relatives. Activities were available and helped people to maintain community links.

People had access to healthcare services and were supported to manage their health. They were supported to eat and drink enough to maintain a balanced diet. They had a choice of meals and drinks. Special dietary

needs and preferences were catered for. Where people needed assistance to eat or drink, staff helped them attentively and with sensitivity. People were weighed at least monthly, or more frequently if there was concern about weight loss. Prompt action was taken to address unplanned weight loss.

Staff had the knowledge and skills needed to carry out their roles. Recruitment systems were robust and helped ensure only suitable staff were recruited. Staff had access to the training they needed. They were committed to their work but expressed differing views of the leadership of the service. Most were positive, but two felt that there was sometimes too much to do in the time available and were unsure whether this would be addressed. People told us there were enough staff around to provide the care and support they needed.

Medicines-competent staff were not always available on site at night. This could result in delays for people who needed 'as required' medicines at night. We have made a recommendation in relation to ensuring there are always medicines-competent staff on site.

People were protected from abuse, infection and avoidable harm. Staff understood their responsibilities in relation to safeguarding adults. They knew how to raise concerns about poor practice. The premises and equipment were kept clean and in good order. There was a team of maintenance staff and a regular maintenance programme. Both parts of the premises were adapted so they were accessible to people with mobility difficulties. Medicines were stored securely. Some information about people's individual risks was out of date and records did not always reflect the support staff had given, for example, when they helped people reposition to reduce the risk of pressure sores. The management team acted immediately on the issues we drew to their attention and were already working on plans to improve record keeping. We have made a recommendation in relation to the provider's policies for the use of anticoagulant medication and the management of falls.

Quality assurance processes were in place to monitor the service's performance and drive improvement. These included regular meetings with people who used the service and with relatives to gain feedback, as well as giving news about recent events and forthcoming developments. There were occasional surveys and regular audits and checks, with action plans to address any shortfalls found. There was a system for bringing about learning and improvement when things went wrong. The registered manager exercised their duty of candour, keeping people and where appropriate their relatives informed about what had happened in relation to accidents and incidents. Complaints and concerns were taken seriously and used to improve the quality of care. The service worked openly and cooperatively with other organisations to ensure people were safe and received the care and support they needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not wholly safe.

There were not always enough medicines-trained and competent staff on duty at night. The service was taking action to address this.

Medicines were stored securely. Staff had not always followed good practice in relation to administering and recording medicines, but the management team immediately addressed issues we drew to their attention.

Most risks to people's safety and wellbeing were reviewed regularly and addressed in their care plans. However, information about people's risks was not always comprehensive or up to date. The management team immediately addressed issues we drew to their attention.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge needed to carry out their roles.

People had a choice of meals and had access to sufficient food and drink throughout the day.

Both wings of the premises were adapted to meet people's individual needs.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity, respect and kindness.

Staff noticed when people are in discomfort or distress and swiftly provided the care and support they needed, in a discreet way.

People's independence was promoted.

Is the service responsive?

Good

The service was responsive.

People and, where appropriate, their relatives were involved in care planning. Staff understood the care people needed.

The service was building links with the community. A range of activities was organised for people on both sides of the home.

Complaints were taken seriously and dealt with thoroughly.

Is the service well-led?

Good

The service was well led.

The service had an open and friendly feel.

People and their loved ones were consulted in a meaningful way.

Quality assurance processes were in place to monitor the service's performance and drive improvement.

The Laurels and Pine Lodge

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 unannounced comprehensive inspection took place on 15 and 17 August 2018, with a brief visit to the service on 21 August 2018 to clarify issues discussed at initial feedback on 17 August and to check what action the service had taken.

The inspection was undertaken by an adult social care inspector and an expert by experience on the first day and two adult social care inspectors on the second day. The lead inspector returned on the third day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case services for older people.

Prior to the inspection we reviewed information we held about the service. This included statutory notifications of significant events such as safeguarding adults investigations, and a Provider Information Return (PIR). A PIR 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. We also obtained feedback from two local authority commissioning and safeguarding adults staff and a health professional who knew of or had contact with the service.

During the inspection we met people who lived in both parts of the service and spoke with 13 people and two relatives. We used the Short Observational Framework for Inspection (SOFI) on the Pine Lodge unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also made general observations around the service, although we did not observe people receiving intimate care. We spoke with six care and activities staff, five clerical and ancillary staff, the registered manager, the nominated individual and the quality support manager. We also reviewed four people's care records, medicines administration records for most people, and records relating to how the service was managed. These included four staff files, maintenance records, incident reports and audits.

Requires Improvement

Is the service safe?

Our findings

People mostly told us there were enough staff around to provide the care and support they needed to be safe. Comments from people and visitors included: "Staff are always available when I need them, I am never rushed at all", "The staff are available when I need them" and "Staff do not rush me. They have time to look after me". One person observed, "Most of the time the staff are available. Sometimes they are pressured, and things are not so good."

Staff were sometimes stretched and had to hurry to complete tasks. Staff rotas were based on peoples' level of dependency. At the time of the inspection, in addition to a head of care and the registered manager during the day, there were one senior care worker and five care workers on duty on The Laurels, and one senior and three (afternoons) or four (mornings) care workers on Pine Lodge. At night there was one senior and one care worker on each side of the building. During the first day of the inspection there was a full complement of staff on duty and people received care in a relaxed and unhurried way. On the second day there was staff sickness and the registered manager was working alongside care workers to provide care. We observed people in the dining and lounge area on The Laurels arguing about who a walking aid belonged to. There were no staff in the vicinity and we had to summons staff using the call bell, to which they did respond promptly. Most of the staff we spoke with told us staffing levels were sufficient, although two staff said care workers were sometimes stressed because of the amount they had to do on a shift.

Staff had not always been deployed at night in a way that met people's identified needs. Most people living at the home were assessed as needing support with medicines. However, at night there was not always a member of staff on site who was trained and competent to administer medicines. If a person was prescribed regular medicines at night, medicines-competent staff would stay late to give the medicine. This had been the case on at least six nights in August 2018, including one evening during the inspection when the registered manager stayed on to give medicines. If people needed 'as necessary' (PRN) medicines at night and there was no medicines-competent member of staff on duty, medicines-competent staff who lived nearby were called in to administer the medicines. They told us they were happy to do this. Even so, this meant there would be a delay in people receiving the medicines they needed as people requesting medicines would have to wait for the member of staff to arrive. In addition, some people living with dementia required a medicines-trained and competent member of staff to assess whether they needed PRN medicines at all.

The management team had identified that calling medicines-competent staff in was not a satisfactory solution. They were in the process of recruiting additional senior staff and were encouraging more staff to become medicines competent. A medicines-trained member of staff was having an observed medicines competency assessment on the first day of the inspection.

We recommend the service maintains its efforts to recruit staff and to train up more staff as medicines competent, so there is always a medicines-competent member of staff on site.

Recruitment systems were robust and helped ensure only suitable staff were recruited. Pre-employment

checks, such as criminal records checks, interviews and obtaining references were carried out as standard practice.

Medicines were stored securely. The temperature of storage was monitored to ensure it was within a range for medicines to remain effective. Bottles of liquid medicines and containers of creams were marked with the date they were opened to help ensure they were not used after they lost their efficacy. Staff who administered medicines had their competency assessed every six months to check they understood how to manage medicines safely.

However, staff had not always followed good practice in administering and recording medicines. Advice from a pharmacist had not always been obtained where people had medicines administered covertly, although this was rectified during the inspection. It is important advice is sought from a pharmacist, as some medicines interact with certain foods and drinks. Medicines administration records (MAR) did not always contain a record of why 'as necessary' (otherwise known as PRN) medicines had been given. There were inconsistencies between some people's MAR and written instructions to staff for administering some PRN medicines. These were addressed immediately we drew them to attention of the registered manager and senior staff. However, the medicines audits as they stood would not have identified such a discrepancy as they did not require this level of detail. The management team advised us they would update the audit template accordingly.

Information about risks and safety was not always comprehensive or up to date. Risk assessments for people covered areas such as moving and handling, falls, the use of bed rails, malnutrition and the possibility of developing pressure sores. Most of these risks were reviewed regularly and addressed in people's care plans. However, where two people were taking medicines to stop their blood from clotting there was no mention of this in their falls risk assessment or care plan, although when one of them fell they received prompt medical attention. We drew this to the attention of the provider and care plans were updated to include an additional care plan in relation to anticoagulant medication. In addition, one person had recently started using bed rails to reduce the risk of them falling from their bed at night. The risks associated with the bed rails had been assessed, but the person's care plan had not been updated accordingly. We drew this to the attention of a senior manager and the care plan was updated. The same person required assistance to reposition every two hours to reduce the risk of developing pressure sores. The person's skin was intact, but care records did not reflect that the person had been repositioned as often as this. The provider's audits had highlighted some issues with record keeping and they continued to monitor this.

We recommend the provider reviews their policies in relation to the use of anticoagulant medication and the management of falls.

People were protected from abuse and neglect. People and relatives told us they felt they were safe, making comments such as, "My relatives are safe here... things do not go missing" and "I feel safe here and my possessions are secure". Staff knew how to identify and report safeguarding concerns. They were also aware of statutory organisations with a role in safeguarding adults. Issues relating to safeguarding, such as restraint, were discussed at staff meetings.

People were protected from infections. Both units were kept clean and fresh-smelling by dedicated cleaning staff, who worked according to a cleaning schedule. People commented favourably on the cleanliness of the premises, for example saying, "The home is kept very clean, so is my bedroom", "The whole place is kept very clean" and, "All looks very clean and [person's] room is kept very well". Handwashing facilities were available where they were needed, and there were antibacterial hand gels around the premises. Staff used

personal protective equipment, such as disposable gloves and aprons, appropriately. Precautions were taken against legionella, which are bacteria that can cause serious illness, colonising the water system. A food hygiene inspection in July 2018 had awarded a score of four out of a possible five. Action had been taken or was under way to address the issues identified.

The premises and equipment were kept in good order. There was a team of maintenance staff and a regular maintenance programme. Lifting equipment such as hoists and bath seats was checked every six months by a qualified engineer. There were regular checks on fire doors and lighting, the fire warning system and fire extinguishers. Fire extinguishers were serviced annually. There were practice fire evacuations several times a year.

There was a system for bringing about learning and improvement when things went wrong. Staff reported accidents and incidents on the appropriate form, which was reviewed by one of the management team to ensure necessary immediate action had been taken to keep people safe. Each accident and incident was logged on the provider's system to enable further analysis by the provider's senior management team, to identify trends that might indicate further measures were needed to prevent similar things happening again.

Good

Is the service effective?

Our findings

People's needs and choices were assessed holistically. Care was planned and delivered based on these, in line with current standards and good practice. There were preadmission assessments to ensure the service would be able to provide the care people needed. When people arrived at the service there was a more in-depth assessment, covering physical, cognitive, emotional and social needs. This was used as a basis for planning care. Assessments and care plans were reviewed and updated regularly, with the involvement of people and their relatives.

Staff had the knowledge and skills they needed to carry out their roles. A person commented, "From what I have seen the staff are well trained here." Staff new to care were expected to complete the Care Certificate, which covers a nationally recognised set of standards that health and social care workers are expected to adhere to. Training in key topics, such as moving and handling, fire prevention, first aid awareness, safeguarding adults, mental capacity, infection control, was refreshed every year or two. Training was delivered face to face and through e-learning. Staff confirmed they had access to the training they needed.

People were supported to eat and drink enough to maintain a balanced diet. They made positive comments about this, for example, "The food is good here. I like it very much", "Food is good here", "Snacks and drinks are always available" and "Food is nice and there is a choice. Portions are quite large". Lunches looked appetising and people clearly enjoyed their meals. People frequently had drinks to hand and were encouraged to drink. Most people on The Laurels selected their menu options the day before. Where people were living with dementia, which could make it difficult to make a choice in advance, they chose from plated meals that staff showed them as they were serving up. Where people needed assistance to eat or drink, staff helped them attentively and with sensitivity.

People's risk of malnutrition was monitored regularly. People were weighed at least monthly, or more frequently if there was concern about weight loss. Prompt action was taken to address weight loss, including referring to GPs with a view to seeking dietitian advice.

Special dietary needs and preferences were catered for. A person commented, "If I am not feeling well they will make me something special." The kitchen staff had up-to-date details of people's dietary requirements, for example in relation to diabetes, swallowing difficulties or culture.

People had access to healthcare services and were supported to manage their health. When they asked to see a doctor, or they appeared unwell, staff arranged for a doctor to see them. People made comments such as, "I use the GP that the home organises for me". Staff also liaised with health professionals such as district nurses and community mental health nurses. Each person's health records contained hospital transfer information, which summarised their key health and care needs, in case they needed to go to hospital.

Both wings of the premises were adapted to meet people's individual needs. Individual bedrooms were of varied sizes and some had ensuite toilets. Some rooms in The Laurels were upstairs and could be accessed

by lifts. There was a programme for redecorating bedrooms when there was a change of occupancy. There were bathrooms, shower rooms and toilets around the building; these were identified by labelled doors. There were hand rails in corridors for people to hold. Each wing had a lounge and dining room. Communal areas had been brightened up with attractively coloured paintwork and soft furnishings. There was a quiet lounge on The Laurels that was on occasion used by people and their relatives, as well as for meetings. There was also a quiet area adjacent to the dining room on Pine Lodge. Both units had adjacent paved garden areas that had been refurbished with the provision of new furniture and planting.

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 the least restrictive possible.

People's rights were protected because staff worked in accordance with the MCA. Staff sought people's consent before assisting them. A person told us, "The staff ask my consent to care." If there were concerns about people's ability to give consent, staff assessed their mental capacity in relation to that particular aspect of their care. Where the person was found to lack capacity, a best interests decision was recorded regarding the least restrictive option for providing care in the person's best interests. People were involved as far as possible in these best interests decisions, and key people such as personal representatives were consulted. Examples of best interests decisions covered matters such as the outside doors being locked and medication.

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). The management team had identified where people were being deprived of their liberty and had applied to the relevant local authority to authorise this. Where DoLS authorisations had conditions attached, they ensured these were met. There was a system for tracking when DoLS authorisations expired and ensuring applications for replacement authorisations were made in good time.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. People and visitors we spoke with said staff were caring, for example telling us, "Staff are very caring and supportive of me", "The staff are very respectful, and they call me by my first name", "The staff do treat me with respect", and "They are very good to me here and the ladies [staff] are lovely." There were many positive interactions, while staff supported people and as they were passing by. There was a sense that people and staff enjoyed each other's company. A person who spent much time in their room commented that staff came and spoke with them: "Nobody leaves me out".

Care staff and managers knew and cared about people who used the service. People and staff called each other by name. Staff knew about people's personal histories and there was information about people on file to help staff get to know them. People's birthdays and achievements were celebrated in consultation with their loved ones.

People were supported to express their views and to be involved in decisions about their care.
Relatives and friends could visit whenever they and the person liked, although the service promoted a 'protected lunchtime' to enable people to concentrate on their main meal. People were encouraged to have personal pictures and possessions around them in their rooms. There was an effort to involve people and, where appropriate, their relatives in regular care planning reviews.

Where possible, staff promoted people's independence. For example, over lunch, staff helped people cut up food if they needed this but encouraged people to feed themselves unless they were unable to do so. A person who needed a lot of assistance with care told us that staff still encouraged them to do what they could for themselves. Staff were regularly reminded of the importance of promoting independence.

Staff respected people's privacy and promoted their dignity. Staff were attentive, noticing when people looked uncomfortable or upset. They were quick but discreet in offering the care and support needed. Personal care always took place behind closed doors, and staff knocked before entering people's rooms. When staff needed to discuss people, they only did so out of the earshot of others.

Good

Is the service responsive?

Our findings

People received care that met their individual needs. Care plans recorded people's individual preferences. They covered areas such as communication, continence, maintaining a safe environment, medical conditions, mobility, night care, nutrition and hydration and skin integrity. Staff had a good understanding of the care people required.

People had access to activities that met their individual needs and helped them maintain community links. People commented, "I do participate in activities. I like anything to do with music. I like making things and we play various games" and "I do get involved with activities. I like singalongs. We get lots of outings and visit around the area." The service employed an activities coordinator, who organised a range of activities in both areas of the home. There was access to the provider's minibus three or four times a year, which enabled trips to local attractions that people had said they would like to visit. On the first day of the inspection, there was a special event happening with a farmyard theme. This involved visiting singers and farm animals, music, and party food. People from both sides of the home were clearly having fun; they were dancing, smiling and laughing. Most of this was happening outdoors, but some people were not well enough to go outside, so some of the animals, including a Shetland pony, were brought inside for people to see and touch. This gave people great pleasure.

The activities coordinator was in the process of developing community links. There were existing links with the parish church, a local children's nursery and a nearby dementia café. People also used facilities such as monthly tea dances at the arts centre and reminiscence events run by the museum service. A local firm had funded two players from a symphony orchestra based in Poole to come and play for people. There was a range of other visitors, such as professional entertainers and choirs and musicians from several local schools.

The service met the Accessible Information Standard. This is a law that aims to make sure people with a disability or sensory loss are given information in a way they can understand and have the communication support they need. Assessments, care plans and hospital transfer information flagged people's communication needs. Staff provided the support people required, such as support to wear hearing aids or glasses and to keep these clean.

Complaints and concerns were taken seriously and used to improve the quality of care. People told us they felt able to raise issues with the management team and that if they had done so, these had been acted on. Comments included, "I did complain once and it was dealt with", "I have not raised any concerns, but I would contact the manager if I was concerned at all", and "No complaints but if I did I would speak to [name] the manager". Information about how to make a complaint was displayed around the home. There were five complaints on file from the past year. These had been taken seriously and addressed promptly.

At the end of their lives, people were supported to have a comfortable and dignified death. Staff worked with GPs and district nurses to provide the support people needed as they were dying, for example ensuring that strong pain-relieving medicines were in place. Where people had expressed preferences about end of life

care, these were recorded within their care plan.

Good

Is the service well-led?

Our findings

The service had an open and friendly feel. People commented positively on the atmosphere, for example, "To my way of looking at it the home is well led. It is a very nice home to be a resident in", "The staff seem very happy working together. There is a very good atmosphere" and, "All seems cheerful here, the staff get on well together".

People and their loved ones were involved with developments at the service in a meaningful way. People's and relatives' ideas and wishes were actively sought for activities. There were regular meetings with people who used the service and with relatives to gain feedback and give news about recent events and forthcoming developments. For example, a meeting in June 2018 had discussed staffing, the home environment and the community dentist. The previous meeting had discussed flu, as some people at the service had been very unwell with flu over the winter. A meeting prior to that had discussed the laundry. There had been an issue with clothes being lost. The registered manager had introduced a new laundry tagging system and a dedicated laundry assistant, which had helped with this considerably. There were also from time to time formal surveys of people, families and professionals; action plans were drawn up and actioned for any issues identified as needing attention.

The registered manager sought to operate an 'open door' policy and during the inspection spent much time on the floor with people and staff, who responded as if this was a regular occurrence. Open communication within the service was promoted through daily '10 at 10' meetings between the registered manager, heads of care, and heads of the catering, domestic, maintenance and administrative staff. These flagged up matters such as accidents and incidents, changes in needs, deaths and new admissions. Staff also received updates through handovers, supervision and staff meetings. A health professional observed that instructions they had given had not always been passed on to junior staff, but that the registered manager and heads of care responded positively when issues were raised.

Staff were committed to their work but expressed differing views of the leadership of the service, associated with the level of stress they were experiencing in their role. There had been a turnover in staff over the past year, but several staff had worked at the service for many years. One of them described a period of upheaval prior to the arrival of the current registered manager. They described the registered manager as "a breath of fresh air" and said, "We have come out the other side of the storm and gone up." They also commented, "He [registered manager] is very caring to everyone. The residents love him. He is courteous and a gentleman, but he can have a laugh. He is caring with the staff. He will always try to support the staff." Most of the staff we spoke with said they were well supported in their roles. However, two staff felt that there was sometimes too much to do in the time available and were unsure whether this would be addressed.

The provider operated an employee recognition scheme that includes a range of benefits and annual 'Hartford Heroes' nominated by peers, people and their families for going above and beyond. There was an emphasis on promoting from within. Only one of the senior care staff had come from outside the organisation. Birthdays and significant events were celebrated for both people who used the service and for staff. The special event on the first day of the inspection involved both people and staff and their families.

Staff organised fund raising events to support the provider's nominated charity.

Quality assurance processes were in place to monitor the service's performance and drive improvement. There was a programme of monthly audits within the service, with additional snapshot audits by the service's quality support manager who visited the service at least every four to six weeks. Any shortcomings identified at audit were addressed in an action plan, which the quality support manager monitored to ensure progress with this. The quality support manager's audits had identified the issues highlighted in the safe section of this report which featured on the service's action plan.

The registered manager was also supported through quarterly managers' meetings. These were a forum for sharing good practice across the provider's services. There was also training and development for registered managers, for example in relation to the CQC fundamental standards.

The service worked openly and cooperatively with other organisations to ensure people were safe and received the care and support they needed. The registered manager had exercised their duty of candour, keeping people and where appropriate their relatives informed about what had happened in relation to accidents and incidents. They had notified CQC of significant incidents, as required by law. Staff knew how to raise concerns about poor practice.

The inspection rating from the last inspection was clearly displayed on both sides of the building and on the provider's website.