Sanpas Limited

Church View Residential Home

Inspection report

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Tel: 01604713098

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oakwood Nursing Home is a residential care home providing personal and nursing care to 19 people aged 65 and over at the time of the inspection. The service can support up to 29 people.

The home can accommodate 29 people in shared and single rooms across two floors in one building. The home has shared communal bathrooms. There is a communal lounge, dining area and courtyard garden.

People's experience of using this service and what we found
The judgement of this service takes into account the previous breaches and rating in each domain.

Risks to people had not been monitored or reduced. At this inspection people were at risk of pressure sores, dehydration, infection, exposure to chemicals and unsafe food safety measures.

Medicine management required improvement. We found a prescribed flammable cream stored incorrectly.

The provider had failed to analyse accidents, incidents or information of concern. When things had gone wrong, preventative measures had not been put in place which led to repeated issues.

The location had inadequate amenities available for people, we found areas of the location to be in a state of disrepair.

People continued to be at risk of falls from height, windows were not consistently restricted. This had also been identified in our previous inspection 28 April 2021.

Care records did not always contain the correct information and people's choices and beliefs had not been followed.

Staff treated people with dignity and respect. However, the provider's systems and processes did not always support person centred care and not all risks had been mitigated to ensure people were safe.

The provider had failed to ensure there was adequate oversight of the service. Quality assurance systems and processes did not identify or address issues in the service during this inspection and the previous two inspections.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however, the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 7 July 2021) and there were two breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to multiple concerns received about risks to people not being managed safely. A decision was made for us to inspect and examine those risks.

We found the provider had not taken effective actions to mitigate the risks.

The inspection was also prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to an investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of clinical care.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in relation to safe care, the premises and oversight of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? This service was not safe Details are in our safe findings below	**Inadequate**
Is the service effective? This service was not effective Details are in our effective findings below	**Requires Improvement**
Is the service caring? This service was not always caring Details are in our caring findings below	**Requires Improvement**
Is the service responsive? This service was not always responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? This service was not well-led Details are in our well-led findings below	**Inadequate**

Church View Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Oakwood Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. There had not been a registered manager employed at the service since March 2021. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection-
We spoke with two people who used the service about their experience of the care provided. We spoke with seven members of staff including the provider's appointed management consultant, deputy manager, nurses, care assistants and the kitchen assistant.

We reviewed a range of records. This included twelve people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and fire safety records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Using medicines safely
At our last two inspections the provider had failed to ensure people received safe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People were not protected from the risk of pressure sores. We found people had not been repositioned in line with their assessed need, one person's pressure relieving mattress was found to be on the incorrect setting.
● People were not protected from the risk of dehydration. We found people's fluid intake charts had not been fully completed or monitored.
● Choking risks had not been correctly transcribed across a person's care records. We found one person required thickened fluids, however sections of the person's care plan stated they drank normal fluids. This meant staff did not have the correct information to support people safely.
● People's clinical care need had not been met. We found one person had not had their catheter changed in line with the frequency determined in their care plan. The provider had failed to identify or action this. This put people at risk of infection.
● Incorrect suction equipment was in place for required clinical care. The required suction tubes were out of stock, the provider had failed to identify or action this.
● People were at risk of harm from unclean and defective equipment as safety checks and cleaning records for hoists, suction machine, thermometers, blood pressure machine had not been completed since June 2021.
● People, staff and visitors were not protected from catching and spreading infection. Cleaning records had not been maintained or monitored, we found visibly unclean areas in the kitchen, toilets and sluice room of the home. Records of high touch cleaning had not been completed since June 2021. The provider had failed to identify or action this.
● People were at risk of unsafe food safety measures. We found rusty plate covers to be in use covering items of food which had been prepared for residents to eat. This placed people at risk of cross contamination.
● Kitchen windows which were open at the time of the inspection did not have screening to ensure pests were prevented from contaminating food. This had also been identified at our previous inspection 28 April

2021. The provider had failed to take any action to reduce this risk.
● People were at risk of exposure to a hazardous substance. Appropriate control of substances hazardous to health were not in place. We identified a cleaning fluid within reach stored in an unlocked room.
● Medicine management required improvement. During the inspection we found a prescribed flammable cream left in a person's bathroom. There was not a risk assessment in place for this.

Systems were either not in place or robust enough to demonstrate safety was well managed and risks were mitigated. The provider failed to ensure the proper and safe management of medicines was in place. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We highlighted our concerns with the provider who following the inspection provided some evidence of action taken to mitigate risk.

● Medicines had been administered correctly by trained nurses, where people were prescribed 'when required' medicine there was information available to staff on how and when these should be administered.
● Medicines had been recorded appropriately; medicine records had been transcribed correctly containing all the required information.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● The provider failed to monitor known risks to people in relation to their skin integrity, catheter care, suction care and hydration. This placed people at risk of abuse which could be prevented.
● Information of concern that had been shared with the provider, about risks to people had not been acted on. We saw evidence that these risks were still current during our inspection.
● The provider had systems and processes in place to safeguard people from abuse, however these had not been followed as the provider had not identified that people were at risk of harm.
● Staff had received training in this area and understood how to report any concerns they had to the provider's appointed management consultant, provider and relevant professionals.

Learning lessons when things go wrong
● The provider had failed to analyse accidents, incidents or information of concern. When things had gone wrong, preventative measures had not been put in place which led to repeated issues.
● Accidents and incident forms had been completed by staff, however they did not provide sufficient follow up information to reduce any further risk.

Staffing and recruitment
● Staff were recruited safely. The service followed safe recruitment processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS)

and obtaining suitable references

● There were enough staff to meet people's individual needs in a timely manner. People were supported by both regular and agency staff members who they were familiar with.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

- The location had inadequate amenities. There was one shower in the building which can provide accommodation for twenty-nine people. The location had two bath's which were labelled out of use. Staff told us this had been the case for "a very long time".
- The provider had not identified or actioned areas of the location that were in a state of disrepair. We found a broken radiator cover with nails protruding from it in a communal corridor, a row of tiles missing in a person's en-suite toilet and another person's bed rail bumper to contain a hole which exposed the inner filling. This compromised people's safety.
- Risks to people of falling from height had not been mitigated, window openings were not consistently restricted and restrictors that were in place did not meet the health and safety executive requirements. This had also been identified at our previous inspection 28 April 2021. The provider had failed to take any action to reduce this risk.

This failing posed a risk that people could be harmed. The provider failed to ensure to all that was reasonably practicable to mitigate these risks. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care records did not always contain the correct information. One person's care plan contained conflicting information about the person's required fluid consistency. One section of the person's care plan stated the person required thickened fluids; another section stated the person required normal fluids.
- People's needs and choices had been assessed and recorded in their care plans. Care plans contained information on how people's choices were to be promoted, we observed staff offering people choices throughout our inspection.

Supporting people to eat and drink enough to maintain a balanced diet

- People were at risk of dehydration. People's fluid intake had not been fully completed or monitored.
- People told us they had a choice of meals and one person told us "I like the food, I don't mind what I have, but it I like it."
- Staff told us they had time to support people with their eating and drinking needs.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Individual mental capacity assessments were not consistently in place. When a person had not been able to make specific decisions, we saw no evidence that the best interest decisions had involved other parties.
● Staff had received training in the MCA and understood the importance of supporting people to make their own decisions.
● We saw evidence that the applications for DOLS had been completed and submitted correctly.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to access healthcare. Records showed us people had regular input from their GP and Nurse practitioner. The service worked in partnership with a GP surgery who conducted weekly reviews of people's ongoing health and wellbeing needs.
● The service had acted promptly when there had been a concern about a person's health. The service had contacted the relevant health professionals to seek advice and support.

Staff support: induction, training, skills and experience
● Staff had completed appropriate training which was suitable to meet the needs of the people they were providing care for. Staff told us they had requested specific training in an area and the provider sourced this for them.
● Staff told us they felt supported in their roles by the provider. Staff attended regular staff meetings. This meant that important information was shared with the staff team and they had opportunity to discuss this as a group.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Staff treated people with dignity and respect. Staff told us how they respected people's privacy and dignity when providing personal care. However, the provider's systems and processes did not always support person centred care and not all risks had been mitigated to ensure people were safe.
- People's religious and cultural needs had been assessed and recorded in their care records, however these had not always been followed and respected. In one person's care plan it was clear due to their beliefs they did not wish to eat certain meats. The food intake records for this person showed they had been given these meats over several months.

People did not receive person centred care. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff promoted people's independence. We observed staff practice and found staff taking time to allow people to complete tasks themselves. One staff member told us "We do not do things for people that they can do."
- We observed staff to be considerate and friendly throughout the inspection. One person told us "I am very happy here, the staff plait my hair for me. I'm very well looked after the staff are lovely."

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives had contributed to their care planning where appropriate. Care plans provided staff with information on the person's views and preferences.
- People and their relatives had been given the opportunity to suggest any improvements to the service by questionnaires.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information on display was incorrect. A board in the main lounge provided people with information about the day, date, month, weather and season. This information was not up to date and could impact on people living in the home that required memory aids.
- People's communication needs were identified and detailed within care plans. Care plans gave staff direction on the methods they should use to assist people with their communication such as using gestures. Staff told us they knew people well and that they spent time listening and talking to people.

Improving care quality in response to complaints or concerns

- The provider had not actioned any improvements to the service following concerns they had received in relative's feedback. A concern had been raised about the décor and furnishings being in need of an update.
- The service had not received any complaints since our last inspection. The provider had a policy and procedure in place of how they would manage these.
- The service had received many compliments, these included several cards from relatives who thanked the staff team for the care provided.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans contained personalised detail on people's routines, such as the time they would like support to get ready for their day and how they would like to be supported with their personal care. Staff told us how they supported people in line with their care plans.
- We observed staff to be attentive and responsive to people's needs. Staff responded to people in their bedrooms who pressed their call bells in a timely manner. People who were sat in the lounge had a staff member with them carrying out activities.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to maintain relationships that were important to them. One person told us "My daughter comes to visit me; she lets me know how the rest of the family are." The home was facilitating visits

in line with the latest government guidance.
● People were supported to take part in activities that interested them, either individually or as a group. The service employed an activities coordinator who provided a range of activities for people such as bingo, art and crafts and music sessions.
● Occasions which were important to people were celebrated, the service employed a kitchen assistant who told us that she prepared food for people's birthday parties.

End of life care and support
● Staff had completed training on how to support people at the end of their life, to ensure their needs and preferences were met.
● People using the service were given the opportunity to express their wishes for the care they would like to receive at the end of their life.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last two inspections the provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had failed to ensure there was adequate oversight of the service. Quality assurance systems and processes did not identify or address issues found during this inspection and the previous two inspections.
- Systems and processes in place were ineffective. Known risks to people in relation to their fluid intake, catheter care and repositioning needs were not monitored or met, which left people at risk.
- Clinical audits had failed to identify when required clinical stock was not available, further to this, audits had not identified when the incorrect clinical stock was in use.
- Care record audits had failed to identify when people's care records did not contain up to date information, or when mental capacity assessments had not been completed in line with the requirements of the Mental Capacity Act 2005 and associated practice.
- Medication and Infection control audits were ineffective; A medication audit had been completed once in 2015 then signed and dated monthly until June 2021, this had not identified any issues or actions in 6 years. An infection control audit had been completed once in 2019 and then had been signed and dated intermittently until June 2021. This had not identified any issues or actions in 3 years.
- Staff feedback was not obtained and staff performance was not evaluated. Staff supervision records were identical, the records were pre-written and photocopied with name changes.
- Health and Safety audits were ineffective. They had not identified that safety checks and cleaning had not been carried out. Environmental risks had not been identified or actioned in relation to maintenance issues, food safety, window restrictors, and chemical storage.
- The service breached the Data protection act. A CCTV camera was in place which monitored the outside front area of the home, however there was no signage to advise people of this.

We found no evidence that people were harmed, however this failing posed a risk that people could be harmed. The provider failed to ensure to all that was reasonably practicable to mitigate these risks. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The service failed to display the most recent CQC inspection rating, we found the rating displayed in the main entrance of the service to be from a previous inspection carried out in October 2019.

This was a breach of Regulation 20A (Requirement as to display performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The service did not have a registered manager in place, the provider had commissioned a part time consultant to support the management of the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their responsibility to keep people informed when incidents happened in line with the duty of candour, however they had failed to identify and action areas of the service which required improvement.
● The provider had notified the commission of reportable events and was open and transparent throughout the inspection process.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider gathered feedback about the service from people using the service and their relatives, this feedback had not been analysed or actioned.
● Staff meetings took place regularly, staff told us they were kept up to date with regular information and updates relating to people's care plans and government guidance in relation to COVID-19.
● Care records contained information which evidenced people's relatives were kept up to date with any changes.

Continuous learning and improving care
● The provider had not addressed the areas they were in breach of, as identified during our past two inspections.
● The provider was open to feedback about this inspection and put actions in place to address some of the concerns we found.
● Staff attended handovers, staff told us they were informed of any changes to people's needs and any important information in relation to their working practice.

Working in partnership with others
● The service worked in partnership with other professionals such as GP's and Optician's to support people to access healthcare when they needed it.

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
Treatment of disease, disorder or injury	The provider had failed to ensure risks to people were monitored or managed appropriately. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The enforcement action we took:

Imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure risks to people were monitored or managed appropriately. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The enforcement action we took:

Imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The provider had failed to provide adequate amenities and had failed to provide a safe environment. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Imposed conditions on the providers registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations2014. Good governance

The enforcement action we took:

Imposed conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display the location's most recent inspection rating.

The enforcement action we took:

Imposed conditions on the providers registration.