Medina View Limited

Wollaton Park Care Home

Inspection report

2A Lambourne Drive
Wollaton
Nottingham
Nottinghamshire
NG8 1GR

Tel: 01159283030

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Wollaton Park Care Home is situated in the Wollaton Park area of Nottingham. Providing accommodation with personal care for up to 40 people, some of whom may live with dementia. At the time of our inspection there were 37 people using the service.

People's experience of the service and what we found:
The service was not well-led. There was a lack of effective governance systems in place to ensure the service was meeting regulations. The provider had not maintained oversight of the service to ensure that people's safety was maintained. There was a lack of effective systems in place to ensure the environment and equipment was safe and clean. Poor infection control practices at the service placed people at risk of harm.

Records relating to people's care did not always contain information and guidance to enable staff to provide the safe care and support people required. Risk management was not in place for some people who were at a high risk of falls and people who may present a risk to others from their behaviour.

Not all staff received training in areas relevant to people's healthcare needs and completed an induction when they started work at the service. People were left at risk of being supported by insufficient numbers of staff without the skills and knowledge to support their identified needs.

We received mixed feedback from both people, and their relatives regarding their opinions of the quality of the care and support they received.

People and their relatives told us staff were kind and caring. We observed positive interactions between staff and people using the service during the inspection.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

People were not fully supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; 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 good (published 8 April 2019).

Why we inspected
The inspection was prompted in part due to concerns received about infection control. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report. Please see the Safe and Well Led sections of this full report.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Wollaton Park Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment; infection control; person-centred care; staffing and good governance 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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? The service was not Safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always Effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service well-led? The service was not Well-Led. Details are in our Well-Led findings below.	**Inadequate**

Wollaton Park Care 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 Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 2 inspectors and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Wollaton Park is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Wollaton Park is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
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. We used the information the provider

sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people and 2 relatives about their experience of the care provided. We spent time in communal spaces observing the interactions between staff and people living at Wollaton Park.
We spoke with 9 members of staff, including the registered manager, the deputy manager, the care plan co-ordinator, care staff, kitchen, maintenance and domestic staff and the service administrator. We spoke with a visiting health professional about their experience of the service.

We reviewed a range of records. This included 6 people's care records and various medicine records. We reviewed 3 staff files in relation to recruitment and 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 and assurance from the provider to validate evidence found. We looked at training data and quality assurance 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 our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were not protected from the risk of infection as staff were not always following safe infection prevention and control practices. Infection prevention and control practices within the service were not effective or robust. Leaving people at risk of harm.
- We found significant areas of concern in relation to poor infection control practice at the service, placing people, relatives and visitors to the service at risk of exposure to infection.
- A number of the rooms we observed were significantly unhygienic with broken furniture and poorly maintained equipment. We discussed this with the deputy manager, and it was addressed immediately. The provider responded to the concerns we raised following our inspection, but we could not be assured that this would be embedded going forward.
- Areas of the home were in a state of disrepair meaning it could not be cleaned effectively. The home was visibly dirty in parts, with stains and malodour observed on some mattresses, bedding, flooring and furniture.

The provider completed a full audit of the mattresses and bedding following our inspection and arranged replacements, but these shortfalls had not been identified prior to our inspection. This placed people at risk of harm from infection.

- We found multiple items of prescribed pressure relieving equipment which were worn, soiled and not marked for specific people's use throughout the service. The provider audits had failed to identify these as a risk to people.

We have also signposted the provider to resources to develop their approach to infection prevention and control. We shared our concerns found following the inspection with the local Infection Prevention and Control Team.

Using medicines safely

- People were supported to receive their medicines in a way that was not always safe.
- Prescribed creams containing medicine were left in people's bedrooms. The risk of these being applied to the wrong people or a person ingesting these was high. We asked the registered manager for these to be stored securely after the first day of inspection. We checked and this had not been completed when we returned on day 2.

The failure to ensure the safe storage of medicines and infection and prevention control measures were effectively managed increased the risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were received, administered and disposed of safely. Staff involved in handling medicines had received recent training around medicines. The registered manager ensured staff were assessed as competent to support people with their medicines.
● Where people were being provided with their medicines covertly, we saw there were appropriate best interest decisions in place to support this.
● Controlled drugs were stored and monitored correctly by the senior in charge. The treatment room for storing medicines was clean, tidy and the storage temperatures were checked daily.
● We observed staff supporting people with their medicines in a discreet way, asking them how they were feeling before they provided them with their medication. People's preferences for taking their medicines was clearly recorded on their administration charts.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse and avoidable harm
● The provider did not assess risks to ensure people were safe. Staff did not take action to mitigate any identified risks. People were not always safeguarded from abuse and avoidable harm.
● One person was identified as requiring observation from staff when eating, due to a history of choking. This person was left alone during lunch and tea and observed picking up food from the floor. This left the person at risk of harm from choking and infection.
● People were at risk as no clear analysis of accident and incidents had been completed to identify any reoccurring risks or identify measures needed to keep people safe. For example, we found regular incidents of a person expressing behaviours that could put themselves and others at risk. These had not been reviewed in the persons plan of care or led to updated risk assessments for the person.
● There were not always enough staff deployed in communal areas. Staff who were allocated to these areas did not always observe people effectively. We found this information was not recorded accurately within people's daily records. This put people at risk of falls or avoidable harm.
● Risk management measures were insufficient for people who were at a high risk of falls and those who may present a risk to themselves or others from their behaviours. This meant staff could not respond effectively to reduce these risks.
● We found 1 person lived with a high risk of falls, and the call bell alarm in their bedroom had not been maintained by the provider. The maintenance records showed this had been faulty since August 2023. Failure to ensure the call bell was working left the person without means to call for support. This increased the risk of them mobilising without support which increased their risk of falls.
● The majority of people we spoke with had concerns about the use of their call bell; either a bell not working, long times for a staff response or people trying not to use theirs during peak periods of personal care to avoid long waits. This left people at risk of harm and was a failure to provide person centred care.
● In relation to call bells, 1 person said, "I only use mine now and then, and it can be 5 to 10 minutes as they're so busy." Whilst another told us, "It can be pretty quick or can be ages. I try not to use my buzzer at their busiest times." We also received feedback from people who expressed concerns around not being supported to access their toilet when they needed to, and the negative impact this had on them.
● One staff member told us they had been raising the call bell faults as a concern for 'weeks' and nothing had been done about this. This lack of action by the provider left people at risk of avoidable harm.

Systems had not been implemented sufficiently to ensure health and safety risks were being mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●The provider did not always ensure there were sufficient numbers of suitable staff. The provider did not

always operate safe recruitment processes.
● Staffing levels were not always consistent to meet people's needs and ensure safety. Staff were not deployed effectively across the service.
● We observed multiple occasions during the inspection where people were left at risk due to staff not being present in communal areas. After lunch on day 1, we saw 13 people in the dining room, with 1 staff member, who left to provide personal care for a person. This left people unsupported and at risk of harm.
● People told us of the impact they felt in relation to staffing. One person said, "There's definitely not enough staff. I have to wait for the toilet, and they [staff], look stressed." Another person told us, "They employ very young people who've not got much of a clue. They're very, very short of staff and try and grab any they can."
● Staff told us they felt staffing levels were too low. One staff member said, "We struggle to keep on top of all the tasks at times. I have been raising [specific issue] with my line manager and it hasn't been sorted."
● We found staff had not always been safely recruited with appropriate references and disclosure and barring service (DBS) checks in place prior to their appointment. This meant the registered manager could not be assured people were protected from the risk of potential abuse from unsafe staff. Disclosure and Barring Service, (DBS) checks provide information, including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The provider failed to ensure there were enough staff deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in Care Homes
People were not able to receive visitors in line with best practice guidance.
● Insufficient systems were in place to enable people to receive visitors when they wished. The provider failed to follow best practice guidance and visits were limited within the home.
● One person told us, "My family have to ring up and arrange to come in." While another person told us, "I have regular visitors, they can come when they like if they inform them."

Learning lessons when things go wrong
● The provider did not always learn lessons when things had gone wrong.
● Systems and processes to review incidents and analyse these to reduce re-occurrence were ineffective. This meant the service did not learn from events and take action to improve quality. For example, although we saw there was an audit in place, there was no evidence of the monitoring of call bells to reduce further risk to people in relation to improving falls management. We have reported on this further under the Well Led section.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. 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

- People's individual needs were not always met by the adaption, design and decoration of the premises.
- The environment was not clean and tidy. Areas of the service required repairs and deep cleaning, especially people's bedrooms and communal spaces. Furniture had not been maintained, leaving people at risk of harm from unsuitable equipment to meet their needs.
- We found multiple bedrooms with en suite bathrooms which had been filled with equipment. This meant people were unable to access their private toilet space independently. Some bedrooms contained so much equipment and clutter they presented a risk to people with impaired mobility or visual impairment.
- One person raised concerns about their bed, they told us, "My bed length isn't great for my size so it's not ideal really." We raised our concerns with the deputy manager regarding the persons bed and the risks this presented to them.

The provider reviewed and replaced furniture which was not fit for purpose after our inspection, but these risks had not been identified prior to this. This left people at risk of harm.

- People had personalisation on their bedroom doors to indicate which room was theirs. People had personal items on display in their rooms, such as photographs or pictures.

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

- People were not always supported to eat and drink enough to maintain a balanced diet.
- Although feedback from people and relatives on the food provision was generally positive, staff deployment was not always sufficient to enable supervision of all people to encourage a positive, safe dining experience. Staff interaction with people during the meals was fairly limited.
- One person told us, "I can't chew easily so have my meals mashed up and any meat cooked down well. Sometimes it comes as a normal meal though and I have to mash it up if I can." This left the person at risk of choking.
- A relative told us, "My family member eats well, but we can't go into the lounge or dining room to join them."

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

- People's needs were not always assessed, care and support was not always delivered in line with current standards. People did not always achieve effective outcomes.
- People's needs were not being robustly assessed or updated following an incident or hospital admission. Some care plans were not in place where people lived with identified risks.

● One person living with a risk of seizures had experienced a serious injury following a seizure on day 1 of our inspection. On day 2 this person still had no effective seizure care plan in place for staff to support them. This left the person at risk of further harm.
● Although people were positive about the activity co-ordinator, there were no structured activities provided for people when this staff member was absent, to engage people to do things they enjoyed.
● People spent time sitting in their bedrooms or communal areas watching television. One person said, "I stay in bed so don't go to anything. No one comes up to spend time with me on games or whatever. I just watch sport on TV." Another person said, "They just put on the TV, but we don't get to choose what to watch. I like doing the bingo and do a lot of embroidery and crochet in my room. I get taken to the shop sometimes."
● Relatives spoke of not being allowed to access the communal spaces to spend quality time with their family members when they visited. The visits were restricted to bedrooms. One relative told us, "We're not included in lounge activities, so I have no idea if my family member does anything."

The provider failed to ensure people's needs were assessed and care was delivered in a person-centred way. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received some positive feedback from a person who said, "They [staff] can't do enough for you." Another person said, "The staff are fantastic and do anything for you." And a relative, told us, "My family member is well looked after, so from what we see, there's enough care."

Staff support: induction, training, skills and experience
● The service did not always make sure staff had the skills, knowledge and experience to deliver effective care and support.
● Staff training was not up to date or relevant for all people who used the service. For example, specific training in Autism, mental health and epilepsy had not been completed. This left people at risk of being supported by staff who lacked the skills and knowledge to provide safe care and support for them.
● Some staff had completed training in supporting people with 'behaviours which may challenge'. However, we did not always see best practice being used during the inspection. One person who lived with mental health needs, was ignored frequently by staff. We raised our concerns following the inspection with the registered manager, the local authority and the external teams supporting this person.
● New staff received an induction and training which the provider had identified as mandatory when they began working at the service. However, we were not fully assured this training had met the identified needs of people because care plans did not contain clear guidance or risk assessments.

We have reported on this further under Safe and Well Led. We made recommendations to the provider regarding staff training, which they implemented following our inspection.

● Staff had completed training in safeguarding of vulnerable adults, fire safety and first aid, and showed they understood their responsibilities in these subjects.

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 MCA 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

● The provider was not always working in line with the Mental Capacity Act.
● There were no risk assessments for one person's cognition. This person lived with a range of conditions which had not been recently reviewed or assessed. Their care plan described this person as being resistant to personal care. There were descriptions of this person being 'aggressive' which is an inappropriate term to describe a person. There was no clear risk assessment or positive behavioural support plan for staff to follow.
● The service were not effectively using the Antecedent, Behaviour and Consequence charts for people who have mental health needs. These are used to record and analyse the behaviours that people are communicating in order to provide appropriate risk management and support for them.
● We found the service was working effectively within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.' We saw where conditions were in place, applications for review and renewal had been made.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider ensured the service worked effectively within and across organisations to deliver effective care, support and treatment. People were supported to live healthier lives, access healthcare services and support.
● We saw from records the service had identified when people required support and arranged for people to access a range of healthcare professionals; including GPs, dentists, opticians, dieticians and health team specialists when they needed them.
● One person experienced a medical emergency during our inspection, and we saw staff were prompt to attend to them. Staff followed the service escalation process, and ensured the persons relatives were kept informed of the event.
● People and their relatives gave positive feedback about the service supporting them to access appointments. One person told us, "The Doctor comes to see me regularly. I think the Chiropodist is due in 2 weeks." A relative said, "We take my family member by taxi for hearing tests, but they see the Chiropodist here."

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider did not have an effective management structure. The provider did not monitor the quality of care provided in order to drive improvements.
- Quality management systems were not effective, and provider oversight of the service was poor. We saw a lack of evidence at our inspection that the provider had identified these shortfalls and we were not assured the provider had made and sustained the required improvements at the service.
- All of the staff we spoke with told us the provider and directors did not carry out regular visits to the service. This left the staff team feeling undervalued and not involved as partners in the service.
- The registered manager and deputy manager had not ensured all referrals to the local authority safeguarding team had been made. Some recent safeguarding concerns that had been raised, had not been shared with CQC. We could not be assured that the relevant agencies had been made aware of all incidents to enable their external investigations.
- The provider had failed to identify they had insufficient staff deployed. The provider had ineffective systems and processes in place to review dependency in order for them to assess the required number of staff required to meet people's identified needs.
- The provider had failed to follow safe recruitment processes. This left people at risk of not being supported by appropriately trained staff who placed vulnerable people at risk.
- Although quality monitoring systems were in place to audit areas such as medicines and weight management, other areas lacked oversight, for example, incidents, the environment and infection control processes.
- The provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety in relation to the risk of poor infection control practice, environmental risks, medicines management, staff skills and knowledge and risks related to people's identified health needs.
- There was no robust service improvement plan in place, to ensure people were in receipt of good quality care and to ensure provider oversight and support for the management team.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- There was not a positive and open culture at the service. The provider did not have a system to provide person-centred care that achieved good outcomes for people.
- The provider and registered manager were unable to demonstrate they had learnt lessons or improved care when issues were identified. For example, we saw that they had reviewed recommendations from a

safeguarding outcome, but not looked at lessons learned or identifying if further training was required for staff.
● One person told us, "I've complained to staff about my alarm not working. It just doesn't get done." Another person said, "I've asked the manager to come up to discuss things, but they haven't. I'd say every day, two or three things go badly wrong."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff were not always involved in the running of the service and their protected characteristics were not always well understood.
● The service did ask for peoples' views on their care through regular meetings, but people felt this did not drive improvements. One person said, "We had a meeting last week and they were asking about the food and things to do. I don't know what they do about it afterwards though." A relative told us, "We know they have a 'Residents chat' but of course we can't go to that."

Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 registered manager was aware of their duty of candour, but we could not be assured this was always being applied, due to the concerns found regarding the lack of information sharing regarding some incidents.

● There was a mixed response from people and relatives regarding the management of the service. Some people felt engaged and involved, others less so. Most people we spoke with felt able to raise their concerns with the registered manager or deputy if they should need to.
● Staff were positive in their feedback about the registered manager and the support they offered to the staff team. One staff member told us, "The registered manager is so approachable, you can go to them about anything, they take the time to talk to people."
● We observed the registered manager during our inspection taking time to speak with people during their daily rounds. They showed warmth and compassion when speaking with people.

Working in partnership with others
● The provider worked in partnership with others.
● The service worked in partnership with visiting health and social care teams to ensure people received timely intervention.
● One staff member told us, "We have a good relationship with the visiting health teams. They are regular visitors, so we can build up positive relationships with them, and ask them questions."
● We received positive feedback from a visiting health professional, who told us the service worked well with them, and implemented their recommendations for people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people's needs were assessed and care was delivered in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure the safe storage of medicines and infection and prevention control measures were effectively managed increased the risk of harm. Systems had not been implemented sufficiently to ensure health and safety risks were being mitigated. This placed people at risk of harm

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough staff deployed