Cygnet Learning Disabilities Midlands Limited

Beeches

Inspection report

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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
Beeches is a residential care home providing personal and nursing care to 12 people aged over 18 at the time of the inspection. Beeches can support up to 12 people across two separate wings, each of which has separate adapted facilities. The service specialises in providing care to people who have autism and/or learning disabilities, often accompanied by complex behaviours that may challenge.

People's experience of using this service and what we found
People were not always protected by the provider's safeguarding processes and procedures. Allegations of safeguarding incidents were not always notified to the appropriate statutory agencies and incident reports were not always accurate or effectively reviewed.

People were not always supported by enough staff to meet their assessed needs. People's individual risks were not always effectively managed. Some people's medicines were not always well managed and the provider's medicine records were not always as accurate as they should be.

Some people's bedrooms were not hygienic and cleanliness in the care home needed to be improved. Staff did not always wear their personal protective equipment (PPE) face masks in accordance with current COVID-19 guidance.

People were not always consistently supported, and staff did not always follow the guidance created by the provider's own multidisciplinary team. The provider did not effectively assess people's compatibility with existing residents before moving new people into the care home.

People's dietary and hydration needs were not always well monitored.

Some people had bedrooms which were clean, pleasant and personalised. Other people had bedrooms which were impersonal and appeared institutional. There were communal rooms available containing leisure and activity equipment which people could chose to use.

The provider's quality monitoring and audit processes were not effective in identifying issues and supporting improvements to be made and the sharing of lessons learned.

Staff protected people from injury but there was a high frequency of incidents at the care home in which staff members were injured.

People were not supported to have maximum choice and control of their lives and staff did not always 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.

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.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People's living environment did not always promote their dignity and rights. People's compatibility was not always considered when new people moved into the service. Although people had person centred support plans in place staff did not always follow them. Staff did not always follow the person-centred support plans when incidents occurred and relied on the use of restraint or temporary seclusion. Managers in the service had allowed a culture to develop in which incidents, restraint, and staff injuries, had become normalised.

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 9 May 2018).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about restrictive care practices and staffing levels. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with management practices, people's living environments, and the management of people's prescribed medicines, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe, Effective and Well-led.

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.

The overall rating for the service has changed from Good to Inadequate This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

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 monitor the service.

We have identified breaches in relation to safeguarding, staffing levels, safe care and treatment, person centred care, governance and quality monitoring processes.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for 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?

Inadequate

The service was not safe

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Beeches

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 one inspector.

Service and service type
Beeches 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 had a manager registered with the Care Quality Commission. This means that they and the provider are 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 on both days.

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. 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.

During the inspection
During the inspection we observed how care and support was given generally. We spoke with three staff, the deputy manager, and the deputy operations director. We reviewed a range of records. This included two people's care records and multiple medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We asked the provider to give us additional evidence about how the service was managed. We looked at training data and quality assurance records. We spoke with the Local Authority Adult Social Care Commissioning team and a social worker who was conducting safeguarding enquiries in respect of concerns about the service. We also spoke with the Contract Officer from a different Local Authority about the placement of a person at the service. We received feedback from three relatives of people who live at the service and 28 staff members.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider's safeguarding procedures were inconsistently applied. Care staff knew how to raise safeguarding concerns with their managers. However, we found one occasion when the provider had not notified the Local Authority Safeguarding Adults team, or the CQC, about an allegation of abuse. This increased the risk of potential abuse being unrecognised. The inspector subsequently notified the Local Authority team about the concerns identified.
- Incidents involving the use of restraint were not always reported. Staff told us not all incidents were recorded and debrief sessions after significant incidents rarely occurred. This meant the provider's ability to review incidents, and take steps to keep people safe, was not effective.
- Incident reports were not always accurate. We witnessed two significant incidents, which involved the use of restraint. We requested copies of the subsequent incident reports to review. The incident report for one of the incidents was not accurate. The second incident report was not provided to us in a timely fashion as it had not been completed by the staff involved.
- The lack of consistent and accurate incident reporting, especially when restraint holds had been used by staff, meant people were at increased risk of potentially neglectful or abusive care practices.

This was a breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People were not always supported by enough staff. Staffing levels did not always match the assessed support needs of people. This meant people did not always receive the support they needed; which increased potential risks and limited the activities they could do.
- Staff told us they were regularly understaffed. A staff member told us, "There are never enough staff on shift and so I feel that we can't safely support our residents all of the time. We do our upmost but if an incident occurs, and a number of staff need to attend, then it leaves few staff members to support the other residents." Another staff member told us, "When we're short it means other residents, that are meant to be 1:1, can't be and can't receive the support they are entitled to."
- Ancillary staffing cover was not always maintained. The provider's cleaning and catering staff did not work on weekends and cover was not always put in place when they were on annual leave or absent. This meant care staff also had to carry out those important ancillary tasks which diverted them away from being able to provide care support to people.
- This meant there were times when people did not receive the support they needed and were at risk from unsafe care.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were safely recruited. The provider undertook pre-employment checks to help ensure prospective staff were suitable to care for people. The provider ensured staff were of good character and were fit to carry out their work.

Preventing and controlling infection

● Parts of the care home were not hygienic. A person's bedroom was unacceptably malodorous and in a poor state of repair. Staff told us this was due to the person's known behaviours. However, the provider had failed to put suitable processes in place to maintain the hygiene and cleanliness of that room. This meant the person was living in an unsuitable environment.

● The provider's hygiene arrangements were not enough to maintain cleanliness and safety. Some people's behavioural characteristics meant it was important to ensure areas were regularly cleaned on a planned and ad hoc basis. At weekends and at other times, care staff were required to carry out those tasks in addition to providing support to people with complex care needs. The need to provide support to people meant care staff were not always able to carry out cleaning tasks and maintain safe hygiene standards.

● The provider's current cleaning and hygiene arrangements meant people, and staff, were at an increased risk of harm due to the potential spread of health infections.

● Some people's mattresses were unhygienic. For example, a person's double mattress was in a very poor condition. A staff member told us the care home only provided single mattresses and that, if people wanted a larger size, they had to purchase them themselves. The inspector raised that with the Deputy Operations Director who confirmed the provider would replace any mattresses which were found to be in an unhygienic condition.

● Staff did not always wear personal protective equipment (PPE) in accordance with current guidance. We saw some staff wearing their PPE facemasks under their nose or chin. We also received feedback from the Local Authority Commissioning team and the CCG Infection Prevention and Control team who had observed similar when they had subsequently visited the care home.

Assessing risk, safety monitoring and management

● People were not always protected from identified risks. For example, the provider had identified a person required a modified diet due to a known risk of choking on certain types of food. Staff regularly offered the person food items which the provider's risk assessment stated posed a high choking risk. This meant the person was at increased risk of harm. This was raised by the inspector with the registered manager who told us they would take action to ensure the person was protected from food related choking risks.

● An outdoor area of the care home was not always safe for the people who used it. There was an outdoor area designed to be safe for people who were known to be at risk from eating non-food items. However, the area was not well maintained or regularly checked by staff. We also received feedback following a Local Authority visit to the service where they had identified items in that area which posed a potential risk to a person who may ingest them.

● Incidents were not always safely managed. For example, a person had a positive behavioural support (PBS) plan in place, created by the provider's own multi-disciplinary team, to guide staff on how to support them. We witnessed two significant incidents during which staff, and a manager, did not follow the person's PBS plan. This meant the person was not appropriately supported to safely de-escalate from displaying behaviours that may challenge.

Using medicines safely

● People did not always receive their prescribed medicine. For example, a person was prescribed medicine,

on an 'as and when required' basis, to help control severe agitation and anxiety behaviours. They had frequent incidents of behaviours that may challenge which required staff to use restraint holds. Although medicine had been prescribed for those specific situations it was seldom administered. Staff told us they did not administer the medicine very often because they did not believe it was effective. This was contrary to the Medical Practitioner's instructions and placed the person at increased risk of harm.

● Guidance for staff was not always available. For example, a person was prescribed a medicine for use 'as and when required'. But there was no information available to staff to guide them as to what circumstances required the medicine to be administered. This increased the risk that the person would not receive their prescribed medicine when required.

● Medicine administration notes were not always accurate. Staff did not always follow the provider's own procedures. When staff manually transcribed details of prescribed medicines onto medicine administration record sheets the information was not always complete. The handwritten entries were not always signed by the staff member, then checked for accuracy and countersigned by a second staff member. This increased the potential for medicine administration errors.

● The provider's medicine audit and review processes did not always protect people from receiving the wrong medicine. For example, a person continued to receive medicine which should have been stopped some months earlier. The care team and the provider's in-house medical professional carried out regular reviews of the person's prescribed medicine and health needs, but they had not identified the error. The inspector raised this with the deputy manager who immediately contacted the prescriber to rectify the mistake.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs, and choices, were inconsistently met. Consistency of support is an important part of meeting the complex support needs of people. Some people received support from staff in line with guidance from the provider's own MDT. Other people did not always. This had an impact on people's wellbeing.
- People were not always appropriately assessed for compatibility before moving into the care home. The provider's assessment process did not consider the potential impact of a new referral on the people already living in the care home; or the impact of existing people on a potential newly referred person. This meant some people were living in proximity to other people with whom they were not compatible. This increased the risk of harm to people and staff.
- Staff told us people had been placed in the home who could not be safely supported. A staff member told us, "I also feel some of the residents are wrongly placed and don't have all their needs met. There are days where we are short staffed and, more often than not, there are days where we can spend 6 or 7 hours of the shift being physically assaulted and it just gets brushed under the carpet."
- The provider had not ensured that support was delivered consistently, and that people's needs were met. This increased the risk of harm to people and staff.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not always feel supported by the provider. Some staff told us the way they were allocated to the more complex people to support wasn't done fairly. A staff member told us, "I love what I do but I'm just burning out all the time due to this. It's so unfairly done to individual people."
- Some staff told us they did not believe the provider's accredited restraint technique training was adequate to meet the needs of the people they supported. A staff member told us, "Our restraint techniques don't always work on these residents, for different reasons, and this makes it dangerous to work with them for risk of injury to yourself or them." This was confirmed by our observation of two incidents when staff were injured while attempting to implement a restraint on a person who was agitated and posed a risk to themselves and others.
- The provider had a comprehensive training program in place for staff and records showed staff had received the training that the provider offered. However, we observed the training was not always effective in guiding staff on how to support people with complex behaviours who required consistent support.

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

● People were not always supported to eat and drink enough. For example, the provider's records showed occasions when a person with complex needs consumed very little. There was no evidence of any action taken when the person refused food or drink for long periods in a day. This meant some people had an increased risk of dehydration or malnutrition.

● People were offered choices of food and drink. Mealtimes were flexible depending on people's individual needs.

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 by the provider's own multidisciplinary team (MDT); consisting of a Psychiatrist, Clinical Psychologist, Assistant Psychologist, Speech and language Therapist and Occupational Therapist who worked closely with the care home team. The service also linked with the local GP surgery and pharmacy.

● Some staff told us the link with the MDT was not effective. A staff member told us, "The MDT barely come down to see our residents, so no work is being done to assess them. I believe better assessments from the MDT could help the Doctors in finding solutions." Another staff member told us, "The MDT don't really understand how [Person] communicates. Staff have learned how to because we are with them for 12 hours at a time. The MDT guidance is a bit useful, but it would be nice if they spent some time with [Person], but that is very rare."

● There was inconsistency in some of the approaches advised by the MDT and the approaches implemented by staff when supporting some people with complex needs. This indicated communication links between the care staff team and the MDT were not always effective.

● Some people were supported to access external services. For example, a person was supported to attend a local college on a regular basis each week. The service also had access to a vehicle to facilitate trips out to other leisure activities in the community.

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

● The physical environment experienced by people was inconsistent. Some people had personalised rooms which met their needs. Other people had rooms which were impersonal and appeared institutional.

● For example, a person's bedroom was completely empty of all fixtures, decoration, and furniture except for a bare mattress on the concrete floor. The registered manager told us they had removed all items as a result of the person's known behaviours. However, no risk assessment or support plan was in place, at the time of the inspection, which evidenced the options considered and that the decision to remove all items and decoration was in the person's best interest. The provider had not discussed the matter with the person's relatives until after the inspector raised the issue with the registered manager.

● The care home had various communal spaces available to people including an art room, a computer room and a lounge containing interactive equipment. Although we did not observe any people using those rooms during the inspection the deputy manager told us some people made good use of them when they chose to.

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.

- Most people had appropriate DoLS authorisations in place and, for those who didn't, we saw the provider had made the necessary referral to the appropriate legal authority and was waiting to hear the outcome of the DoLS application.
- People were supported by staff who had received training in DoLS and MCA and understood how the principles should be applied in practice. The principles of the MCA were being followed.

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 good. 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.

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

- The provider's governance systems had not ensured staff followed their medicines policies and procedures in relation to the recording and review of people's prescribed medicines. Similar concerns had been raised previously with the provider in January 2020 and the provider assured CQC lessons had been learned and improvements implemented. We found improvements had not been sustained.
- The provider's governance systems had not ensured staff followed people's PBS plans. This meant the support some people received was often inconsistent which potentially increased people's distress and anxiety behaviours.
- The provider's quality assurance and audit systems had not ensured hygiene and cleanliness standards were maintained in order to protect people from possible harm.
- Staff told us the day shift team morale was low. They told us this was due to a lack of support from the registered manager, and provider, in respect of challenging incidents. For example, a staff member told us, "When staff get hurt, which is a daily occurrence, and not small injuries; but getting covered in bruises, black eyes, or bitten, we get told its your job!" The inspector raised the issue of staff injuries with the registered manager who stated that, "[Staff] knew the type of service when they signed up to work here."
- Staff told us they did not always feel listened to by the registered manager or provider. A staff member told us, "Sometimes I feel management aren't willing to listen to us and how we are actually feeling. I feel it's very much their way and that's it." Another told us, "When incidents occur, they tell us they are positive interactions. I feel management and the rest of MDT just tell us that to keep us from moaning, when we are actually getting hurt."
- Failing to appropriately implement the provider's governance processes and procedures meant the registered manager did not effectively assess, monitor and improve the quality and safety of the services provided to people.

Continuous learning and improving care

- Incident data was not used effectively to review and improve the care provided to people. For example, the provider's records showed that in June 2021 there were 19 incidents in which staff were injured while supporting people. A staff member told us, "The amount of assaults on staff here! Managers seem to think this is expected in the workplace. We have been told not to take it personally and that it comes with the job. We get assaulted on an almost daily basis."
- Opportunities to learn from incidents were missed. We witnessed one incident in which multiple staff were

assaulted by a person, and one staff member sustained an injury which required them to be sent to Hospital. The provider's incident review process did not include potentially important factors about the incident and did not identify that staff attempts to implement approved restraint holds had not been successful. This meant the provider's incident review process was not effective in identifying ways to improve care.

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 provider had not always notified us about events which they are legally required to do. For example, a staff member had used a non-approved restraint hold on a person during an incident. Other staff had told the provider, and the provider had investigated the allegation, but the provider had not notified us, or the Local Authority Safeguarding team, about the allegation of potential abuse. The failure to notify us about such incidents impedes our ability to monitor the quality of care.

● People's relatives were informed by the registered manager when incidents occurred involving their relative. One relative told us, "I think we have an excellent relationship with the managers there. They always seem to be helpful when I contact them. I have nothing but praise for the staff there."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us they had been kept regularly informed about visiting and contact arrangements during the COVID-19 pandemic. Families told us they had valued that communication from the registered manager.

● The provider had an appropriate equality and diversity policy in place and staff received training in how to ensure people's equality characteristics were considered when providing care to them.

● Details of people's individual equality and diversity characteristics were recorded in their care notes and considered when care was being planned.

Working in partnership with others

● Following our inspection, the provider accepted offers of guidance and support from the Local Authority Commissioning team, CCG Medicines Optimisation Team and CCG Infection Prevention and Control team. The provider also commissioned an external Pharmacist to support them by carrying out a full audit of the medicine records and processes in the care home.

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 the care and treatment of service users was appropriate, met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management of medicines; that adequate hygiene arrangements were in place to reduce the potential for the spread of health infections; and that all reasonable steps were taken to mitigate the individual identified risks of people receiving care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure consistent systems and processes were in place to safeguard people from the risk of abuse and improper treatment.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that consistent and effective systems and processes were in place to assess, monitor and improve the quality and safety of the services provided to people receiving care.

The enforcement action we took:

We issued the provider a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the needs of the people receiving care.

The enforcement action we took:

We issued the provider a Warning Notice