Arden Manor Care Limited

Arden Manor Care Home

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

Summary of findings

Overall summary

About the service
Arden Manor Care Home is a care home providing personal care to 11 people at the time of the inspection. The home is registered for up to 23 people. Some of the people were living with dementia. People have access to their own bedroom along with communal spaces including lounges and gardens.

People's experience of using this service and what we found
Risks to people were not managed in a safe way. After incidents occurred action was not always taken to mitigate the risk of further occurrence. Staff did not always have the information to keep people safe and this placed people at risk of harm and an inconsistent approach. People were not always protected from abuse as incidents were not always documented to ensure appropriate action was taken.

People were not 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.

Infection control procedures had improved however there were still areas that required action. There were still some areas within the home that were in need of repair. Medicines management required improving as people did not always receive their 'as required' medicines as prescribed and protocols for covert medicines were out of date.

Staff received training however we were not assured the competency processes in place were effective to ensure staff had the skills and knowledge to support people in a safe way. People's independency and dignity was not always promoted.

The systems and audits in place were not robust or effective in identifying areas of improvements. There was no evidence lessons were being learnt when things went wrong. Feedback had started to be obtained from people and their relatives however no action had been taken when areas of improvement had been suggested.

There were enough suitably recruited staff to offer support to people. People enjoyed the food available and were offered a choice. They also had the opportunity to spend time with their families and participate in activities they enjoyed. There were plans in place for people 's end of life care.

Peoples needs were assessed and reviewed and they were happy with the care they received. Health professionals' advice was sought when needed and this advice was followed within the home. There was a complaints procedure in place. We were notified by the provider of events that occurred within the home.

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

Rating at last inspection and update
The last rating for this service was inadequate and there were breaches of regulations. We issued 2 warning notices following our last inspection. (Published 9 March 2023) The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

The overall rating for the service has remained inadequate based on the findings of 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 Arden Manor Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to how people are safeguarded, the care and support they received in relation to risk management, capacity and consent and the systems in place to ensure the home is effectively governed.

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

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

Arden Manor 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.

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 2 inspectors.

Service and service type
Arden Manor Care 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was not 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 our last inspection, including notifications the provider had sent to us and information we had received from the public. We also gathered feedback

from the local authority.

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 used all of this information to plan our inspection.

During the inspection
We spoke with 3 people. We also spoke with the registered manager, the deputy manager, the nominated individual, the provider, and 2 members of staff. We looked at the care records for 6 people. We checked the care people received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within service, staff recruitment checks and medicines records for 11 people.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 inadequate. At this inspection the rating for this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice.

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

Assessing risk, safety monitoring and management

● Individual risks to people were always not assessed, monitored and reviewed. One person had fallen 4 times in less than a month. Although medical advice was sought after each incident no action had been taken to reduce the risk of reoccurrence. After the fourth fall on the advice of paramedics action was taken and no further falls had occurred. A care plan and risk assessment was then introduced. This meant the provider had not taken action to mitigate this risk and keep this person safe.

● When care plans had been introduced to keep people safe, they were not always followed. For 1 person we saw documented when they were in bed there should be a crash mat next to their bed and a sensor mat in place. We saw that the sensor mat was not plugged in, and the crash mat was away from the bed posing a risk to this person. This placed this person at an increased risk of harm should they roll from their bed.

● Care plans that had been introduced since our last inspection lacked detail and this resulted in staff inconsistently supporting people. For example, 1 person's care plan stated they needed 'checks to be carried out' as they were unable to use a call bell, there was no further guidance for staff. We saw documented in this person DoLS these checks should be every half an hour, however staff told us they did this less frequently. The records we reviewed showed this person was left more than an hour without a check, placing the person at an increased risk of harm.

● Another person was identified as being 'at risk' of skin damage on their assessment. The care plan stated they needed 'regular turning' for pressure relief. There was no detailed guidance in place for this. We saw this person remained in the same position for several hours during our inspection and was not seated on a pressure cushion. No one was able to confirm to us if they should be sat on a pressure cushion. We reviewed the records for this person and we saw they would go for long periods without pressure relief often over 8 hours. This placed this person at an increased risk of developing sore skin.

● When people were displaying periods of emotional distress there were not always plans in place identifying how people should be supported during these times. We saw documented on 'behavioural charts' one person displayed periods of throwing objects, physical abuse, self-harming and locking themselves in their room. There were no plans in place identifying these concerns or how staff might support the person. This placed people and others at continued risk of harm.

● Environmental risks were not always safely managed. On arrival we saw a door to a room, with chemicals

and cleaning products stored in, was unlocked. This remained unlocked for over an hour. During this time, we saw people who were independent were near this area. This placed people at risk of harm as chemicals and cleaning products were not stored safely.

Learning lessons when things go wrong

● Lessons were not being learnt when things went wrong within the home as the provider remains in breach of regulations and has not complied with the warning notices issued.

● Despite some improvements since our last inspection, we found incidents were not always reviewed to reduce the risk of reoccurrence.

Using medicines safely

● When people were prescribed 'as required' medicines these were not always administered when needed. We saw one person was prescribed medicine for agitation; this was frequently administered. It was not documented on the medicine administration records (MAR) why this person had received this. We reviewed the daily notes and found there were not always records to show this person was agitated at the time they were given this; it was sometimes recorded they were 'content'. We also found that when it was documented they were agitated they had not always received this medicine as needed.

● Another person had a protocol in place to receive their medicines covertly. This is when staff administer medicines without the person's knowledge. We saw this protocol had not been updated when a change to how these medicines should be administered had been made. This meant this person was at risk of not receiving these medicines how they were prescribed.

Risks to people were not always fully considered. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When people were prescribed regular medicines, these were administered to people when needed. One person told us, "They give me my tablets everyday they are very good and know how to do them."

● Staff were trained to administer medicines to people and a competency check was also carried out with staff. Since our last inspection staff administering creams to people had also received training and a competency check in this area.

At our last inspection the provider had failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of regulation 13 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 13.

Systems and processes to safeguard people from the risk of abuse

● The systems in place to ensure people were protected from abuse were not always followed as incidents were not always recorded or reported.

● When incidents had been recorded these were investigated and reported to the safeguarding team. However, we could not be assured all incidents had been reported as needed. During our inspection we saw various incidents where people were in receipt of verbal abuse. None of these incidents were documented and therefore no further action was taken. This placed people at an increased risk of abuse.

● Staff told us they had received training and were able to explain safeguarding to us. However, we were not assured they fully understood this as they were not recording all incidents that were occurring within the home.

● When restrictions were placed upon people the principles of MCA were not followed. One person had a series of falls. Paramedics advised to put bedrails in place to keep this person safe which was completed. However, this person could not consent to this. There was no mental capacity assessment in place for this and this was not recorded as being in their best interests. The provider had not considered alerting the DoLS team to this restriction to ensure the DoLS authorisation was updated. This placed this person at risk as they were being unlawfully restricted.
● Another person had a sensor mat in place. They could not consent to this. There was no mental capacity assessment in place for this and this was not recorded as being in their best interests. The provider had not considered alerting the DoLS team to this restriction to ensure the DoLS authorisation was updated. This placed this person at risk as they were being unlawfully restricted.

People were not protected from potential abuse as incidents were not always documented and reported so that action could be taken. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Although improvements had been made since our last inspection, further improvements were needed. We saw there remained cracked paint in toilets and a chair that was ripped remained in the lounge for people to use.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● There were no restrictions placed on visiting and visitors could access the home freely.

At our last inspection the provider had failed to ensure there were enough staff available to support people. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider is no longer breach of regulation 18.

Staffing and recruitment
● There were enough staff to support people and they did not have to wait for support. One person told us, "I think there are enough yes, there is always someone I can call on if I need a hand, I don't wait long."
● We saw staff were available in communal areas to offer support to people when they needed it. When people pressed their call bells to seek assistance these were answered in a timely way. Staff we spoke with felt there were enough staff. One staff member said, "Yes now the amount of people has reduced there are enough staff."
● Staff had received the relevant pre-employment checks before they could start working in the home to

ensure they were safe to work with people.

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 requires improvement. The rating for 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.

At our last inspection the provider had failed to ensure the principles of MCA were followed. This was a breach of regulation 11 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 11.

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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met. We checked whether the service was working within the principles of the MCA.

- The principles of the MCA continued not to be followed or understood. People did not have decision specific capacity assessments or best interests decisions in place when needed.
- One person had a capacity assessment in place. The decision that was being made was documented as 'To make simple and complex decision'. There were no individual capacity assessments in place including the use of bed rail and medicines management. This placed this person at risk of not receiving care and treatment they had consented to or in their best interest.
- Another person had a sensor mat in place, there was no individual capacity assessment in place for this. This placed this person at risk of not receiving care and treatment they had consented to or in their best interest.
- There was a lack of understanding from the management team around capacity and consent. When we raised concerns that a capacity assessment was not in place for a person we saw a member of the management team tried to complete this in the office, they did not involve the person or their families with

this. This demonstrated there was a lack of understanding around this process.

The principles of MCA were not always followed. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
● Staff did not always have the knowledge or skills to support people. Records confirmed and staff told us they had received training. We could not be assured this was effective in ensuring people's needs were met and they were kept safe. For example, staff had received training in safeguarding, however they were not recording incidents that occurred between people, to ensure they were protected from abuse.
● Staffs competency was checked in areas such as medicines management, although staff had been deemed competent in this area, we could not be assured this was accurate as they were not administering 'as required' medicine as prescribed.
● Staff told us they had received an induction when starting in the home; this included training and shadowing more experienced staff so that people could get to know them.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● Improvements had been made since our last inspection and people's health needs were responded to when needed. People had access to health professionals including GP's, occupational therapists and speech and language therapists.
● When needed people had care plans in place reflective of advice offered by professionals and these were followed during our inspection.
● People's oral health care was considered and there were plans in place identifying the levels of support they needed.

Supporting people to eat and drink enough to maintain a balanced diet
● Improvements had been made since the last inspection and we saw people's dietary needs were assessed and reviewed. When people had guidance from health professionals around eating and drinking there were care plans in place and this was followed during our inspection.
● There was a choice of meals available for people. We saw people were verbally asked what they would like. One person told us, "Yes the food is good, it's hot when it is supposed to be, if I just fancy something small like a sandwich, they will do this for me."
● People were offered a choice of hot drinks and snacks throughout the day.

Adapting service, design, decoration to meet people's needs
● There were some improvements to the home since our last inspection and we could see areas had been cleaned, repaired and refurbished. Further improvements were needed as some areas still required painting and furniture replacing.
● Further improvements were needed to ensure the home was more dementia friendly. For example, there continued to be limited signs or pictures to offer guidance or support to people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The care plans now demonstrated who had been involved with the planning and reviews of people's care. We could not be assured these processes were always followed as we observed MCA being completed in the office by staff.
● People's needs were assessed before they started using the service. This considered people's gender, culture and religion. People's physical and health needs were also assessed and considered. This

information was now reflected in people's care plans and risk assessments.

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 our last comprehensive inspection, we rated this key question good. The rating for this key question has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always treated in a dignified or caring way as their individual' needs were not always understood.
- Although staff were able to tell us some information about people and what was important to them, they did not always have the guidance in place that showed how people were to be supported. This meant staff supported people in an inconsistent way.
- Although we observed some kind interactions between people and staff, staff did not always take action to ensure people were well treated. For example, one person was subjected to verbal abuse by another person and staff did not intervene.
- People's independence was not always encouraged or promoted; we observed one person who could walk independently was being transported around the home in a wheelchair.
- People's privacy was promoted. We observed this during our inspection. One person said, "'They always knock my door before they come in."
- People were happy with the staff that supported them and raised no concerns. One person said, "The staff are very good, they are all kind."

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

- There was now evidence to show people and their families had been involved with their care planning and reviews. Although, it was unclear when people had dementia or non-verbal communication how they were involved with this process and staff we spoke with were unable to explain this to us.

Requires Improvement

Is the service responsive?

Our findings

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

At our last comprehensive inspection we rated this key question good. The rating for this key question has changed to requires improvements. This meant people's needs were not always met.

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

- People did not always have control over their lives as all people were not always encouraged to express opinions.
- Care plans introduced were not always detailed or reflective of people's current needs as reported on under safe domain of this report.
- When care plans were in place, they had been updated and were reflective of people's preferences, including their likes and dislikes. There was now detail in place showing which people and family members had been involved with their care planning.
- Care plans were also reflective of people's cultural needs and they support they may need.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carer's, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were not fully understood within the home. When people had dementia for example, there were no plans outlining the support they may need. Some of the information displayed in the home may have been confusing for people. For example, there was a printed food menu on the table for people. However, staff wrote on a chalk board the meal for the day, this was different to the menu. There was no pictures or verbal prompts for people to consider. This meant people may not have been effectively able to make or communicate their choices.
- Other people had communication plans in place that identified how they communicated. There were also plans in place identifying what people's first language was and how they were supported with this.

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 had the opportunity to participate in activities they enjoyed. One person said, "I join in if I fancy it, it passes the time some days." We saw that during our inspection some people were singing and there was a crafts session.
- People were supported to have regular contact with their family and friends.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place. No complaints had been made however the provider told us they would follow their policy if needed.
● People knew and felt able to complain. One person said, "'I would tell the staff if I wasn't happy with something I am sure they would put it right."

End of life care and support
● There were plans in place for people when they were coming to the end of their life, detailing their wishes.

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 inadequate. The rating for this key question has remained the same. 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 inspection the provider had failed to operate good governance systems to assess, monitor and improve the quality and safety of the services provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice.

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

Continuous learning and improving care. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- Various audits had been introduced since our last inspection however they were not robust or effective in identifying all areas of improvements.
- The audits in place had failed to identify that restrictions had been placed upon people without the legal power to do.
- The systems and audits in place had failed to identify people's care plans did not have sufficient detail in them to keep them safe. They had failed to identify where people were not receiving an adequate change of position placing them at an increased risk of developing sore skin. They had also failed to identify a person had fallen 4 times and no action had been taken to mitigate the risk of this reoccurring, placing then at continued risk of harm.
- The medicines audits were not effective as they had not identified a covert medicine protocol was out of date or that another person was not receiving their 'as required' medicines as prescribed.
- There was a system in place to ensure staff were competent to administer medicines to people however this was not effective as staff had failed to administer 'as required' medicines to a person as prescribed.
- The incidents and accidents audits had not identified reviews were not being completed after each incident or accident had occurred. The audit had not highlighted that care plans and risks assessment had not been updated to ensure people's risks of continued harm were effectively mitigated.
- Infection control audits had identified that furniture needing condemning, however the furniture had been left in the communal areas for people to use.

There remained insufficient oversight of the service and the measures in place were not always effective in identifying areas of improvement. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We had been notified about events that had happened within the service when needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

● People did not always receive person centred support as the provider, registered manager and staff did not always fully understand the needs of people, such as dementia, periods of emotional distress and communication. This placed people at an increased risk of not receiving person-centred care.

● People's outcomes were not always positive as the provider had failed to ensure they received care that was safe.

● People felt happy living in the home and with the care they received. One person told us, "The staff are good I am happy here I have no complaints."

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

● Feedback had started to be sought from people and relatives, satisfaction surveys were completed. However, no action had been taken to collate this information or use this to make improvements within the home, despite concerns being identified. The registered manager told us they were in the process of reviewing this information.

● Staff felt supported and listened to. One staff member told us, "I can go to the management team if I need to, I find they are supportive to me." Staff attended supervisions and team meetings so that they could share their views.

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

● As the provider was not always identifying incidents within the home we could not be assured duty of candour requirements were fully understood and met.

Working in partnership with others

● The service worked with other agencies to ensure people received the care they needed.

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 11 HSCA RA Regulations 2014 Need for consent The principles of MCA were not followed or met.

The enforcement action we took:

We issued a NoP to cancel 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 Risks to people were not always fully considered.

The enforcement action we took:

We have issued a NOP to cancel the providers registration.

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 People were not protected from potential abuse as incidents were not always documented and reported so that action could be taken.

The enforcement action we took:

We issued a NoP to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There remained insufficient oversight of the service and the measures in place were not always effective in identifying areas of improvement.

The enforcement action we took:

We have issued a NoP to cancel the provider registration.