Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Ratoath Manor Nursing Home
Name of provider:	Ratoath Nursing Home Limited
Address of centre:	Ratoath, Meath
Type of inspection:	Unannounced
Date of inspection:	07 May 2026
Centre ID:	OSV-0000152
Fieldwork ID:	MON-0050282

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Ratoath Manor Nursing Home is set in the village of Ratoath in County Meath. The two-storey premises was originally built in the 1820s and is located in landscaped gardens. It now provides accommodation to 60 male and female residents over 18 years of age. Residents are admitted to the centre on a long-term residential, respite and convalescence care basis. The service provides care to residents with conditions that affect their physical and psychological function. Residents of all dependency levels are provided for. Residents are accommodated in single and twin bedrooms across three units; St Oliver's Unit, St Patrick's Unit and Ground Floor Unit. A proportion of these bedrooms have en-suite sanitary facilities. Communal shower rooms, bathrooms and toilets are available throughout the building. A variety of communal rooms are provided for residents' use across both floors, including sitting, dining and recreational facilities and an oratory. A number of outdoor areas are also available, including large gardens on the ground floor and two internal courtyards on the first floor. The registered provider employs a staff team consisting of managers, registered nurses, care assistants, activity coordination, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 May 2026	09:20hrs to 16:00hrs	Sinead Lynch	Lead
Thursday 7 May 2026	09:20hrs to 16:00hrs	Sheila McKevitt	Support

What residents told us and what inspectors observed

During this unannounced inspection, the overall feedback from residents was that they were happy and content living in the centre. Residents told inspectors that there were enough staff to meet their needs and staff spoken with concurred with this. Residents were observed being assisted by staff throughout the morning and encouraging them to take part in activities on offer.

Notwithstanding the positive feedback provided to inspectors from residents and visitors, inspectors observed gaps in relation to the management and oversight of premises, the complaints process and assessments and care planning. These are discussed in further detail under their respective regulation.

Residents bedroom were observed to be clean and well organised and the residents informed the inspectors that their bedrooms are always kept clean and tidy. However, one resident did say that their laundry can take 'ages' to be returned.

On the morning of the inspection residents and staff were hosting a morning tea party in aid of Alzheimer's society of Ireland. Residents' families had been invited and a number attended together with residents. Inspectors saw a wide range of beverages and confectionery on offer for the guest and residents in the main dining room.

Residents were observed engaging in exercise classes throughout the afternoon; they were actively engaged with the physiotherapist facilitating the group session and they appeared to be enjoying the class.

The meal time experience was relaxed and residents appeared to be enjoying the food served to them. There was choice for each meal and alternative consistencies were provided where required. There were adequate numbers of staff available to support residents in the dining room. There was drinking water available throughout the centre.

Staff attended to residents in a dignified and courteous manner. When call-bells alarmed there was an appropriate response from staff. However, inspectors observed three call-bells that were not functioning on the day. There were either not plugged in or not working. This was identified on the previous inspection and continued to be a concern on this inspection.

Information regarding advocacy services was displayed around the centre. Inspectors were informed that residents were supported to utilise this service when required.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management

affect the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that the management team had implemented improvements since the last inspection in relation to some parts of the premises, records and infection control. However, further actions were required to come into compliance with Regulation 17: Premises, Regulation 5: Individual assessment and care plan and Regulation 34: Complaints procedures. These are discussed further in this report under their respective regulations.

This was an unannounced inspection conducted over one day by two inspectors of social services. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended) and follow up on the actions taken by the provider since the previous inspection. Following the inspection of 7 January 2026 there had been a cautionary meeting with the registered provider who assured the Chief Inspector that they will take prompt remedial actions to ensure a safe, quality service and bring the centre into compliance.

Ratoath Manor Nursing Home Limited is the registered provider of Ratoath Manor Nursing Home, which is part of the wider group Silver Stream. There was a clearly defined management structure in place with identified lines of authority and accountability.

A new person in charge had been appointed since the last inspection and, at the time of this inspection, had been in post since February 2026. They worked full-time in the centre and were supported in their operational management role by an assistant director of nursing (ADON), staff nurses and a team of healthcare assistants. From a governance perspective, there was support from a senior clinical governance team who attended the centre regularly.

There were regular audits in place in the centre that had identified areas for improvement and learning. In most cases there were appropriate action plans in place. However, an audit that identified areas for improvement in relation to meal times did not have an action plan in place, therefore no improvements could be made.

Records of complaints were made available for review. There was one complaint that remained open. From a review of other complaints received in 2026 they were found to be appropriately investigated. However, the complainants were not informed in writing of the outcome of their complaint or any improvements identified following the investigation, as a result those that made complaints were not

informed of the appeals process. This is not in line with local complaints procedure or the regulatory requirements.

The storing of residents' records had greatly improved since the previous inspection. Records and residents' medication was now stored securely in a lockable press.

Notifiable incidents were submitted to the Chief Inspector in line with regulatory requirements and an incident and accident log was maintained in the centre.

There were regular management team meetings which included reviews of any accidents or incidents, complaints or premises issues identified. Minutes of these meetings were provided to the inspectors. There was an annual review of the centre and a quality improvement plan in place. The residents' opinions and their views were taken into account when developing this annual review.

Regulation 14: Persons in charge

The person in charge had recently commenced in the role. They had the necessary qualifications and experience as required by the regulations. They worked full-time in the centre in a supernumerary capacity.

Judgment: Compliant

Regulation 21: Records

The registered provider had in place all records set out in Schedule 3 of the regulations. These were stored safely and were accessible and made available for inspection.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the progress made and that management systems were in place and generally ensured that the service provided was safe, there were other findings of concern to include repeated premises related issues, as found in the previous inspection in January 2026. This was despite commitments given by the provider that all outstanding actions had been completed and were evidenced by the following:

- Three bedrooms were found to have call-bells that were not functioning, and had not been reported as faulty by staff. This meant that residents could not ask for assistance when they needed.
- The paths and grounds around the centre were not well maintained to ensure they were safe for residents to mobilise as they wished.
- The oversight of care plans was not effective as detailed under Regulation 5: Assessment and care planning.
- The oversight of complaints management was not robust, as detailed under Regulation 34: Complaints procedure.
- Some of the audits completed could not meaningfully inform quality improvements. For example, the meal time audit had findings but there was no action plan or time-frame set for the identified issues.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had notified the Chief Inspector of Social Services of any accidents or incidents within the required time-frame.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was not followed in relation to one complaint that had been received. For example:

- There was no written response informing the complainant whether or not their complaint was upheld, the reasons for that decision, any improvements recommended and details of the review process.

Judgment: Substantially compliant

Quality and safety

This inspection was carried out to review the quality of the service being provided to residents following up on action plans from the last inspection carried out in January 2026. Inspectors found that the provider was proactive in their approach and were progressing towards addressing the issues previously identified. As a result the

quality of care being delivered to residents, the infection prevention and control practices and medication storage had improved some what, however there was more work to be done to bring the centre into full compliance. Improvements were still required in relation to the premises, and individual assessment and care planning, as further detailed under their respective regulations.

There was a wide variety of activities made available to residents, which they were seen actively participating in. Residents had access to internet, television and radio. They were facilitated to lock their bedroom and en-suite door and for those living in twin bedrooms screening was in place to ensure their privacy. However, inspectors randomly checked a number of call-bells and found three that were not in working order. This meant that these residents could not call for assistance when or if required. This is the second inspection in 2026 where some call-bells have been found not to be functioning in resident bedrooms.

There were arrangements in place to assess residents' health and social care needs upon their admission to the centre, using validated assessment tools. These were used to inform the development of residents' care plans; and they were reviewed every four months. However, the random sample of care plans reviewed by inspectors were not reflective of person-centred care and were not updated following review of the residents' by members of the multi-disciplinary team or after an incident which warranted a change in the care being delivered. There were several care plans that did not reflect the most up-to-date care the resident required as per their assessment, posing a risk that residents were not provided with evidence-based care.

Infection prevention and control practices had improved and the environment appeared to be managed in a way that minimised the risk of transmitting a healthcare-associated infection. Equipment in use, furniture and fittings appeared clean. New water fountain drip trays had been ordered and they were waiting to have them installed.

Medications were now stored securely in all areas of the centre. The door into the nurses’ station was secure and the medicine fridge was locked.

Some improvements had been made to the premises; the centre was now heated throughout and all bathrooms and toilets were functional and accessible to residents. However, the premises was not in a good state of repair inside or outside. Although painting preparation work had been completed, this work had not been progressed in a timely manner.

Residents with greater dependency needs that required additional supports were provided with appropriate assistance and had allocated staff to ensure their social and care needs were effectively met.

Regulation 17: Premises

The premises did not conform to the matters set out in Schedule 6. For example:

- Emergency call-bell facilities were not accessible from each resident's bed and in every room used by residents. This is a repeated non-compliance.
- A more proactive approach to internal maintenance was required as unsightly signs of wear-and-tear could be seen in some areas. For example, there was damage present and plaster could be seen on the walls in some bedrooms where damage had been caused from beds and where polyfill had been used to fill the holes in the wall; however, the walls had not been fully repaired or painted over making these areas unsightly and not homely for residents living in these units.
- External areas of the centre accessible to residents required maintenance. For example, the garden to the rear of the building was not well-maintained; there was part of a wall that had been damaged and wooden benches in a poor state of repair, making them inaccessible to residents.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider had ensured that procedures, consistent with the national standards for the prevention and control of health care associated infections were implemented by staff.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medications were now stored securely in all areas of the centre including those areas which could be accessed by residents or visitors.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The quality of care planning was inconsistent and there were numerous examples where regulatory requirements were not met, as follows:

- Care plans did not consistently reflect residents' needs. For example, the recommendations made by visiting members of multi-disciplinary team were

not always entered in residents' care plans, hence the care plan was not detailed enough or up-to-date to direct the care the resident required. Two residents who had been reviewed by a dietitian did not have the recommendation made; reflected in their nutritional care plan.

- One resident who had been assessed by a speech and language therapist did not have the professional recommendations, reflected in their nutritional care plan.
- One resident who had been involved in a safeguarding incident notified to the chief inspector did not have included in their care plans the safeguarding measures outlined in that notification or the type of abuse displayed by the resident.
- A sample of residents' hygiene care plans were reviewed, some did not reflect person-centred care. For example, one reviewed stated "daily wash, weekly shower" another stated "offer shower weekly and wash daily", in line with a more task-based institutional approach to care.

Judgment: Not compliant

Regulation 9: Residents' rights

Some residents' choice was not always upheld. Three residents were denied the right to call for assistance due to faulty call-bells in their bedroom.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ratoath Manor Nursing Home OSV-0000152

Inspection ID: MON-0050282

Date of inspection: 07/05/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A centre-specific compliance action tracker has been developed to monitor all actions arising from this inspection. The person in charge will review the tracker weekly with ADON, CNM, maintenance operative and relevant heads of department. Progress will also be reviewed through governance meetings and facilities review meetings until actions are completed and embedded in practice.

The Registered Provider Representative Team held a staff meeting with the person in charge following the inspection. This meeting addressed the inspection findings, immediate improvement actions, staff accountability, reporting responsibilities and the requirement to escalate any issue that may impact resident safety, rights or quality of care.

Management walkarounds have been strengthened to include direct checks of call-bell access, resident-accessible areas, premises concerns, care practice and any immediate risks to residents. Unannounced night-time checks have also commenced to ensure that call-bells are connected, accessible and functioning.

The audit process has been reviewed and discussed with the Person in Charge to ensure that audits lead to meaningful quality improvement. Audits must include findings, required actions, responsible persons, target dates and follow-up review.

Governance information, including progress against the compliance action tracker, audit findings, overdue actions, recurring issues and escalation requirements, will be shared with the Registered Provider Representative Team through the Governance reports.

Oversight of care planning, complaints and premises has been strengthened, as further detailed under each regulation addressed in this compliance plan.

The management team is confident that these improved governance arrangements will address the findings from this inspection and support sustained compliance across the centre.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The open complaint identified during the inspection has been reviewed and closed. The complainant received a written response outlining the outcome of the complaint, whether the complaint was upheld, the rationale for the decision, any improvements identified and the review process available.

The complaints policy has been updated to ensure that all complaints, including verbal and written complaints, receive a written outcome response. Where the required response timeframe cannot be met, the complainant will receive written confirmation of the reason for the delay and the revised timeframe for response, in line with the complaints policy.
A standard complaints outcome letter template has been shared with the person in charge and management team. This template includes the required fields for complaint outcome, rationale, improvements recommended, review process and review outcome, where applicable.

Complaints are reviewed weekly by the Person in Charge and the Clinical Governance Team to ensure they are investigated, responded to in writing and closed within the required timeframes.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider and person in charge have reviewed the premises findings and have implemented a premises action plan to ensure that resident areas comply with Schedule 6 of the regulations.

A full call-bell audit has been completed across all bedrooms, en-suites, toilets, bathrooms, communal rooms and resident-accessible areas. Any defective, disconnected or inaccessible call-bells have been immediately repaired, replaced or made accessible.

Where a call-bell fault is identified, staff will implement an interim resident-specific safety plan immediately. This will include enhanced monitoring checks until the fault has been resolved and the call-bell has been confirmed as functioning.
The person in charge has completed 2 nighttime spot checks to ensure that call-bells are fully connected, accessible and functioning. Further unannounced nighttime checks are planned as part of the centre's oversight arrangements.
Additional call-bell checks will continue during management walkarounds. Any non-compliance, delay in reporting faults, or failure to follow escalation procedures will be reviewed through the centre's governance process and addressed in line with the company's performance management and HR policies, where required.
A proactive approach to ensuring fabric finishes to walls, floors and ceilings are maintained to a good standard is now in place. A painting contractor has been scheduled to complete the painting work to all corridor areas and a program of resident room painting upgrade works is currently being rolled out. Rooms will be prioritized based on current conditions as well as availability. Doors, frames and architraves which have sustained impact damage from walking frames and wheelchairs are currently being addressed throughout the home.

External resident-accessible areas, including paths, gardens, benches and the damaged wall, will be risk assessed and included in the premises action plan. Unsafe furniture will be removed from use until repaired or replaced.
The rear garden and outdoor areas will be maintained to ensure that residents can safely access and use outdoor spaces where they choose to do so. Additional personnel will be assisting the maintenance operative for the home to action works to the outdoor areas.
Premises actions will remain under review through the centre's Facilities Review meeting until completed.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A review of all multidisciplinary team recommendations received over the previous 3 months has been completed to ensure that these recommendations are reflected in residents' care plans and implemented in practice.
Safeguarding incidents have also been reviewed, and residents' care plans have been updated to reflect the safeguarding measures required, identified risks, and any resident-specific support arrangements.

A process has been implemented to ensure that care plans are reviewed and updated following any MDT review, significant incident, safeguarding concern or change in residents' assessed needs. The nurse on duty and responsible for the resident's care will update the care plan. The night nurse will complete a follow-up review to ensure that no

relevant information has been missed. The person in charge, ADON or CNM will provide oversight through care plan audits, incident and complaints reviews.
All MDT recommendations will be communicated to staff through daily handover. The handover process has been reviewed and improved to ensure that key clinical changes and updated care requirements are clearly communicated.

Care plan training is being provided to registered nurses to improve the quality, accuracy and person-centred nature of care planning. This training is being delivered in a practical format to support implementation and embedding of learning into practice.
Although training compliance is high, practical care planning workshops will continue until the management team is satisfied that nurses have the required knowledge and that improvements are evident in residents' care plans. The aim is to ensure that care plans describe residents' individual preferences, assessed needs and required supports, rather than task-based routines.

Ongoing care plan audits will be completed by the PIC, ADON and CNM to ensure that improvements are sustained. Any gaps identified will be addressed through supervision, further training and review at the centre's governance meetings.

Given that Regulation 5 has been identified as a repeated area of non-compliance, the registered provider and management team have given this regulation a high level of priority. The actions implemented are designed not only to address the specific findings from this inspection, but also to strengthen the overall system for assessment, care planning, review and oversight.
The management team is confident that these measures, supported by ongoing audit, supervision, practical training and governance review, will bring the centre into compliance and ensure that compliance is maintained.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Registered Provider and Person in Charge have reviewed the findings under residents' rights, particularly the impact of faulty call-bells on residents' ability to call for assistance.

The Registered Provider Representative Team and the Person in Charge held a staff meeting following the inspection. This meeting addressed the inspection findings, immediate improvement actions, staff accountability, reporting responsibilities and the requirement to escalate any issue that may impact residents' safety, dignity or ability to exercise choice.

The person in charge has completed 2 nighttime spot checks to ensure that call-bells are fully connected, accessible and functioning. Further unannounced nighttime checks are

planned as part of the centre's oversight arrangements.

Additional call-bell checks will continue during management walkarounds. Any non-compliance, delay in reporting faults, or failure to follow escalation procedures will be reviewed through the centre's governance process and addressed in line with the company's performance management and HR policies, where required.

An immediate call-bell audit and repair programme has been implemented, as outlined under Regulation 17. This will ensure that call-bells are accessible and functioning from residents' beds and in all resident-accessible rooms.
Where a call-bell fault is identified, staff will implement an interim resident-specific safety plan immediately. This will include enhanced monitoring checks until the fault has been resolved and the call-bell has been confirmed as functioning.

Feedback from residents about call-bell access, response times, and provision of care will continue being reviewed through residents' meetings, daily engagement and governance meetings.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/09/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	10/06/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant	Substantially Compliant	Yellow	10/06/2026

	whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	10/06/2026
Regulation 34(2)(g)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as appropriate, in the event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.	Substantially Compliant	Yellow	10/06/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably	Not Compliant	Orange	10/06/2026

	practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/07/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	10/06/2026