Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Saimer View
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	07 May 2026
Centre ID:	OSV-0002495
Fieldwork ID:	MON-0044244

About the designated centre

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

Saimer View Community Group Home provide both shared and full-time residential care and support to adults with a disability. The centre comprises of one six bedded bungalow with one of the bedrooms being used as a staff office and overnight accommodation. Saimer View is located on the outskirts of a rural town, with the residents having access to centre transport to enable them to access activities of their choice. The centre provides residents with their own bedrooms as well as communal facilities such as kitchen dining rooms, sitting rooms, and bathroom and laundry facilities. Residents are supported by a team of team of health care assistants and staffing requirements are based on the assessed needs of residents. At night, residents are supported by a sleep over staff member. In addition, the provider has arrangements in place to provide management support outside of office hours, weekends and public holidays when required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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	10:35hrs to 17:25hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

The service in this centre was person-centred. The rights of residents were respected. Residents were supported to make choices and decisions about their daily lives and these were respected by staff. The residents were supported by a consistent staff team who were familiar to the residents. Staff had up-to-date training. The provider maintained an overview of the quality of the service through regular audits. Improvement was required in relation to the residents' assessments of their health, social and personal care needs. Improvement was also required in relation to residents' risk assessments, the completion of refurbishment works, and providing assurances in relation to the effectiveness of the fire doors.

This was an unannounced inspection of this centre and formed part of the routine monitoring of the service completed by the Chief Inspector of Social Services. It was facilitated by the person in charge.

The centre consisted of a bungalow on its own grounds. It was located on the edge of a large town. Each resident had their own bedroom. There were two shared bathrooms in the house. The house had a sitting room and a kitchen-dining room that also had a seating area with a television. There was a utility room and a staff sleepover bedroom that doubled as an office. Outside, there was a garden to the front and back of the house. There was a paved area at the back of the house. The person in charge reported that there were plans to ready the garden and outdoor area for the summer months. The driveway had recently been widened to accommodate a second vehicle in the centre. The person in charge reported that the second vehicle had resulted in more opportunities for residents to leave the centre alone rather than travelling with peers.

Since the last inspection of this centre, a number of refurbishment projects had been completed. The centre had been fitted with new windows and a new front door and back door. The person in charge reported that the residents had chosen the new windows and doors. The person in charge also reported that improvements to the insulation of the house had been completed. The heating system in the house had been converted from oil to an air-to-water system. The person in charge said that these changes in the house had resulted in a warmer home for the residents.

The internal front porch had been removed so that the front door opened directly into the hallway. This improved accessibility at the front door. The painting and decorating of this area was not fully complete on the day of inspection. New flooring had been fitted in the hallway and in the staff sleepover bedroom. In the sitting room, a new fireplace had been installed and an electric stove had been inserted. There was a new suite of furniture in the sitting room and in the seating area of the kitchen. These had been chosen by the residents. The person in charge reported that there were plans to replace skirting boards and to paint the areas where

renovations had been completed. The shower curtain in the main bathroom was removed and replaced with a shower screen.

Though there had been significant refurbishment in the centre, additional work was required to address some ongoing issues. In one resident's bedroom, there was an area of black discolouration on the ceiling. In the bathroom used by all residents, the vent covering was kept in place with tape. In some areas of the house, there were signs of wear and tear and décor was dated. For example, the paint on the walls in the kitchen was chipped in places. In one of the bathrooms, a plastic shower curtain remained around the level access shower. The person in charge reported that the removal of the curtain from the other bathroom had benefitted the residents and made it easier to use the shower, yet this had not been addressed in the second bathroom. In addition, there was a corner bathtub that the person in charge said was not used by residents and the wall covering was wallpaper. Though this bathroom was of a similar size and design to the other bathroom in the house, the person in charge reported that it was infrequently used by residents.

Improvement was also required to ensure that fire doors were maintained so that they were effective in the event of a fire. The inspector noted that there was a crack in the timber on the jamb of the door between the kitchen and hallway. In addition, there were chips and damage to the bottom of the door. The inspector also noted that thumb-turn locks had been placed on internal doors into the kitchen and sitting room. This will be discussed later in the report under regulation 28: fire precautions.

The inspector had the opportunity to meet with four of the five residents. The fifth resident was not staying in the centre on the day of inspection. The inspector met the residents in the afternoon when they had returned to the centre. The residents told the inspector that they were happy in their home. They said that they liked the house and were happy with the new windows and doors. They said that they liked the staff. Residents knew the names of the staff members and spoke about them. Residents said that they felt safe in their home and that they could tell staff if anything was worrying them or if they had a complaint. Residents spoke about their day and what plans they had coming up. They spoke about the places that they liked to go and things they liked to do in the evenings and weekends. They spoke about their families and their friends.

In addition to the person in charge, the inspector had the opportunity to meet with two other staff members. These members of staff were very knowledgeable on the needs of the residents and the supports that should be offered to meet those needs. They knew the residents' routines and their preferences. They spoke about how they supported residents to go to the places that they liked; for example, the cinema, the mart and shopping. Staff spoke about offering choices to residents and respecting those choices. They spoke about residents making their own decisions about their lives. They knew what to do if a safeguarding incident occurred. Staff spoke about the positive behaviour supports that they offered residents and this was in line with the information contained within the residents' behaviour support plans.

The atmosphere in the house was warm and relaxed. Residents chatted comfortably with each other. The inspector observed the interactions between residents and

staff. These were friendly and good-humoured. Staff responded quickly when residents asked for assistance. Staff knew the names of the people who were important in residents' lives; for example, names of extended family members and friends. Staff chatted with residents about upcoming family events and events that had taken place in the past. The inspector noted that the plan for the evening was decided by the residents and that their choices were respected. At one point, all residents were planning to leave the centre to go shopping but changed their minds and decided to stay at home. This was supported and respected by staff.

The next two sections of this report present the inspection findings regarding the governance and management in the centre, and how this impacts the quality and safety of the service provided.

Capacity and capability

The provider had systems that were effective at monitoring the quality of the service. Staffing numbers and skill-mix were in line with the needs of residents. The provider submitted notifications to the Chief Inspector of Social Services in line with the regulations.

The provider maintained oversight of the service through routine audits and by inspections of the service by members of senior management. Incidents that occurred in the centre were reported, reviewed and measures put in place to avoid a recurrence. A review of these incident reports found that the provider had submitted all notifications to the Chief Inspector as required under the regulations.

The staff in the centre were familiar with the needs of residents and the supports required to meet those needs. Staff had up-to-date training in modules that the provider had identified as mandatory. The provider had also ensured that staff had received additional training in areas that were specific to the needs of residents in this centre.

Regulation 15: Staffing

The staffing arrangements were suited to the needs of residents. The required number of staff was on-duty with the necessary skill-mix to meet the needs of the residents.

The inspector reviewed the rosters in the centre from 1 January 2026 to the day of inspection. This showed that the required number of staff was on-duty at all times.

The rosters also showed that the staff team was consistent and familiar to the residents.

The person in charge reported that the service was supported by a nurse. As part of their role, they provided support with residents' medical and healthcare appointments.

There had been a change to the staffing arrangements in the centre in recent weeks. The person in charge reported that an additional member of staff was now on duty during the day on weekdays. This meant that residents could be supported to take a day off from their day service and attend other groups or activities. On the day of inspection, a resident was supported by this staff member to attend an advocacy group meeting and go out for lunch.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training in this centre was up-to-date. This meant that staff had been given the opportunity to develop the necessary skills and knowledge to ensure that residents received the supports required to meet their needs.

The inspector reviewed the records maintained by the person in charge in relation to staff training. This showed that staff had up-to-date training in modules that the provider had identified as mandatory. In addition, staff had up-to-date training in modules that were identified as necessary for the residents in this centre.

Judgment: Compliant

Regulation 23: Governance and management

The provider had systems to maintain oversight of the quality of the service and had clear lines of accountability. However, improvement was required to ensure that all service improvement issues were identified and addressed within the timelines set out by the provider.

The management structure was clearly defined. Staff knew who to contact should an issue arise in the service. The inspector reviewed the records of incidents that had happened in the centre since 1 January 2026. This showed that incidents were recorded and escalated, as required. The person in charge completed a monthly overview of the incidents to ensure that any trends could be identified and additional measures put in place to reduce recurrences.

The provider monitored the quality of the service through routine audits completed by the person in charge. There was a schedule of audits for the year. The inspector reviewed the audits completed in the centre since the beginning of 2026 and found that audits were completed in line with the schedule.

The provider completed unannounced visits of the centre to monitor the quality of the service. The inspector reviewed the reports from the last two visits in January 2026 and July 2025. These reports outlined specific actions to address issues noted on these visits. In addition, the provider completed an annual report into the quality and safety of care and support in the centre. The most recent annual report was completed in February 2026 and outlined specific actions to improve the service. However, the inspector noted that not all actions were completed in line with these timelines. This will be further discussed under Regulation 17: Premises. In addition, not all issues identified by the inspector had been detected or addressed through the provider's monitoring systems. For example, damage to fire doors was not recorded on audit and one resident's assessment of their health, social and personal care needs had not been updated since 2023.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had submitted notifications to the Chief Inspector in line with the regulations.

In preparation for this inspection, the inspector reviewed the notifications that had been submitted in relation to this centre since the last inspection. The inspector also reviewed the record of incidents in the centre that had been recorded since January 2026. This found that the provider had submitted all notifications, as required. This showed that the provider was aware of their obligations under the regulations and were transparent in sharing necessary information with the regulator.

Judgment: Compliant

Quality and safety

The service in this centre was person-centred. Residents were supported to communicate their needs and wishes. Their decisions and their rights were respected. Where required, residents had positive behaviour support plans and received supports in line with these plans. There were systems in place to protect residents from the risk of abuse.

Improvement was required in relation to the assessments of the residents' health, social and personal care needs to ensure that assessments were carried out at least annually. There was also some improvement required to ensure that all identified risks to residents had corresponding risk assessments to guide staff practice. Improvement was required to ensure that refurbishment issues in the centre were addressed in line with the provider's timelines. Assurances in relation to the effectiveness of fire doors in the centre was required.

Regulation 10: Communication

The provider ensured that residents were supported to communicate their needs and wishes. The provider ensured that staff had the required knowledge and skills in relation to the specific individual communication supports required by residents.

The inspector reviewed the information available to guide staff in relation to the communication supports required by three residents. These documents showed that residents were able to access speech and language therapy services in relation to their communication. One resident had a report on file from a speech and language therapist that outlined specific supports and strategies for the resident. The inspector noted that these supports were available in the centre.

The information in the residents' plans gave guidance to staff on how to present information to residents to ensure that they understood it fully. There was also information for staff on the meaning behind residents' specific phrases and gestures.

The inspector observed staff chatting comfortably with residents. They were aware of the residents' communication strategies and used them effectively.

Judgment: Compliant

Regulation 17: Premises

The premises were suited to the needs of the residents and the house was accessible to all residents. However, improvement was required to ensure that refurbishment issues were addressed in a timely manner.

As outlined in the opening section of the report, the centre had extensive refurbishment works completed since the last inspection. This had resulted in positive changes for the residents. However, improvement was required to ensure that all refurbishment works were completed in line with the provider's own timelines. As noted, an area of discolouration was on the ceiling in one resident's bedroom. This was recorded on the last unannounced visit to the centre in January 2026 with a target date of 28 February 2026 for its removal. Further, the centre's

most recent annual report set a date of 30 March 2026 for its removal. However, on the day of inspection, this had not yet been addressed.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems for the assessment and control of risk. However, improvement was required to ensure that all risks were recorded and clear guidance available to staff.

The inspector reviewed the risk assessments that were developed for two residents. For one resident, risk assessments were developed within recent weeks and were in line with findings from their assessment of need. There were clear control measures and the risk assessments signposted staff to other relevant documents; for example, behaviour support plans. However, for the other resident, risk assessments for all known risks were not recorded. For example, there was a known risk in relation to road safety and negative interactions with a fellow resident. There were no risk assessments on file to guide staff on how to promote the safety of the resident in relation to these matters.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had systems to protect residents from the risk of fire. However, assurances were not available on the day of inspection in relation to the effectiveness of the fire doors in the centre.

The inspector reviewed the documentation in the centre in relation to fire safety measures. This showed that regular fire safety checks were completed by staff in the centre. The centre's emergency lighting and the fire detection and alarm system were regularly checked by an external fire company.

Evacuation plans were developed that outlined the supports that staff should give residents in the event of an evacuation. These were reviewed by the inspector. Fire drills happened regularly and these were in line with these evacuation plans. The inspector reviewed the records of the two most recent fire drills and found that they contained detailed information. The records showed that differing scenarios and staffing levels were simulated during these drills.

The person in charge reported that fire doors had been assessed and repaired since the last inspection of the centre. This included the replacement of handles and hinges to ensure that they met fire safety standards. However, further improvement

was required to provide assurances that the centre's fire doors were effective. As stated in the opening section of the report, the fire door between the hallway and kitchen showed signs of damage. The last fire door check in the centre was completed on 8 January 2026 and this damage was not recorded on that audit.

Further, the inspector noted that the new handles on the doors of the kitchen and sitting room included thumb-turns. The thumb-turns were located inside the rooms rather than on the hallway side of the doors. This was not in keeping with best practice as it meant that fire doors along a protected escape route could be locked and thereby impede an evacuation in the event of a fire.

The inspector reviewed an email from an external fire safety professional dated April 2024. This email listed works that needed to be completed on fire doors at that time following a survey of the doors. These works were completed. However, the email included a recommendation that all door frames in the centre be fire sealed. The fire safety professional could not determine at that time if this had been completed. On the day of inspection, the provider was unable to provide assurances that this recommendation was in place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Improvement was required to ensure that the health, social and personal care needs of residents were assessed at least annually and that corresponding information was available in relation to the supports required by residents to meet those needs.

The inspector reviewed the assessments of the health, social and personal care needs that had been completed for three residents. Though one resident's records indicated that their assessments had been completed in recent months, the other two residents' records indicated that they had not been updated in the last year. In one case, the health, social and personal care needs assessments were not dated. This meant that it was unclear if the assessments had been completed in the previous 12 months. In addition, the resident's care plans were devised over 12 months ago and dated April 2025, indicating that the assessments had not been completed in line with the timeframe set out in the regulations. For the other resident, the assessments and care plans were completed in 2023 and some care plans had not been updated in the intervening time. This meant that staff did not have the most up-to-date information to meet the needs of residents and to offer appropriate supports.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had systems in place to support residents to manage their behaviour.

The inspector reviewed two behaviour support plans and noted that they had been developed by an appropriate professional. They had been developed with input from the resident and staff members in the centre. The plans gave information on how to maintain a supportive environment for the resident and how to respond when the resident needed additional support.

There were no recorded restrictive practices in this centre. The person in charge completed quarterly audits to ensure that any practices that were restrictive were identified. The inspector reviewed the two most recent audits in February and April 2026 and found that they were completed in line with the provider's timelines.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in this centre to protect the residents from abuse. .

The inspector reviewed intimate care plans that had been developed for two residents. These gave specific guidance to staff on how to support the residents.

The inspector reviewed a closed safeguarding plan in the centre. This showed that the incident was recorded appropriately and that the provider had followed their own safeguarding procedures in relation to this incident. Support was sought from members of the multidisciplinary team to ensure that the incident did not reoccur.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were promoted in this centre.

The inspector observed that residents' decisions and choices were respected in the centre. Staff spoke about how the residents made choices and how these were respected.

The inspector reviewed the daily notes for three residents. These notes recorded how choices were offered to residents. For example, one resident's notes recorded that the resident had met with staff on a one-to-one basis to decide what activities they would like to do for the weekend.

Judgment: 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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Saimer View OSV-0002495

Inspection ID: MON-0044244

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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	Substantially Compliant

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

Master Fire, Life Safety Systems attended the centre on 11th May to assess the damage to the fire-door between the kitchen and hall. Master Fire Life Safety Systems carried out an additional 6-point check on all fire doors in the centre on 18/05/2026 to ensure that all fire doors are to the correct standard and certified. awaiting report.
• Registered Provider will ensure remedial works required to all fire doors will be completed by 30/07/2026
• HSE Maintenance Department with a Building contractor, attended the Designated Centre to carry out a walk around of the premises and issued report of works required in the centre. Completed 25/05/2026
• The Registered Provider will ensure painting in kitchen, surrounding walls of the fireplace, front hall and replacement to skirting will be completed by 30/07/2026
• HSE Maintenance Department treated the black discoloration on the ceiling in one resident's bedroom and reviewed the external roof and tiles on 26/05/2026.
• A full assessment is required of the external roof and internal attic to determine the cause of discolouration of ceiling in one resident's bedroom. To be completed by 30/07/2026
• The Registered Provider will ensure remedial works required for the external roof and internal attic will be carried out by 30/09/2026
• The Person in Charge with the Registered Provider has contacted Parents and Friends on 29/05/2026 to plan for refurbishment to two bathrooms in the centre and upgrade to utilities. Registered Provider will ensure action is completed by 30/09/2026
• Person in Charge reviewed and updated one resident's assessment of need including their health, social and personal care needs and a timeframe for the evaluating care plans is identified. Action completed 31/05/2026
• Person in charge developed risk assessments for one resident, including Road Safety and Negative interactions with fellow peer to ensure clear control measures are in place to guide staff. The Person in Charge will ensure that all risk assessments will be

monitored three monthly in line with policy. Completed 31/05/2026.
• Person in Charge has commenced review of a second residents assessment of need and care plan. This includes transferring information over to the new Sligo/Leitrim Assessment of Need template to ensure the most accurate information is available to staff to meet the needs of residents. Action to be completed by 14/06/2026
• The Person in Charge has now a system in place to capture time frames for evaluation of the support plans in the assessment of need for all residents in the designated centre.
• The Register Provider has ensured that monitoring systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored through audits and centre's QIP which will be submitted monthly to the Director of Nursing. Completed 05/06/2026

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• The Person in Charge contacted Maintenance department who attended the centre with a building contractor to assess refurbishments and upgrades required in the centre. Completed 26/05/2026
• Skirting boards to be replaced, painting of the ceiling and walls in the kitchen, around the fireplace in the sitting and front porch to be completed by 30/06/2026
• Maintenance removed tape from vent in resident's bathroom and sealant applied to area. Action completed 26/05/2026
• HSE Maintenance Department treated the black discoloration on the ceiling in one resident's bedroom and reviewed the external roof and tiles on 26/05/2026.
• A full assessment will be completed on the external roof and internal attic to determine the cause of discolouration of ceiling within the centre by 30/07/2026
• The Registered Provider will ensure remedial works required for the external roof and internal attic will be carried out by 30/09/2026
• Person in Charge replaced the plastic shower curtain in one bathroom with a shower screen. Action completed 08/06/2026.
• The Person in Charge with the Registered Provider has contacted Parents and Friends on 29/05/2026 to plan for refurbishment to one bathroom and upgrade to utilities. Action to be completed by 30/09/2026

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• The Person in Charge developed a risk assessment on road safety for one resident including supporting documentation of a care plan, easy read material and information on road safety. Completed on 31/05/2026
• The Person in Charge reviewed one resident's How to Keep Me Safe Document and Safeguarding Support plan. The Person in Charge introduced a risk assessment on the Negative interactions with a fellow resident to ensure clear controls measures are in place to guide staff on how to promote the safety of the resident. Action completed on 31/05/2026

• All staff in the centre have been updated on the new risk assessments that are in place. This has been discussed at daily handovers and staff meeting. Completed 09/06/2026
• The Person in Charge will ensure that all risk assessments will be reviewed three monthly in line with policy. A monitoring system has been established through the centre audit schedule and QIP which will be submitted monthly to the Director of Nursing 05/06/2026.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• Person in Charge contacted the maintenance department who attended the centre on 11th May to assess repairs required to the thumb-turns on the kitchen and sitting room doors. Maintenance replaced the Thumb Turns with a standard key lock mechanism. The registered provider has ensured there is no keys in the locks or stored in the centre, therefore the doors cannot be locked. Action completed on 12/05/2026.
• Master Fire, Life Safety Systems attended the centre on 11th May to assess the damage to the fire-door between the kitchen and hall. Master Fire Life Safety Systems carried out an additional 6-point check on all fire doors in the centre on 18/05/2026 to ensure that all fire doors are to the correct standard and certified. awaiting report.
• Registered Provider will ensure remedial works required to all fire doors will be completed by 30/07/2026

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• Person in Charge has updated one resident's assessment of need and are in line with residents health, social and personal care needs. Action completed 31/05/2026
• Person in Charge has commenced reviewing a second residents assessment of need and care plan. Review of the assessment of need includes transferring the most up-to-date information over to the new Sligo/Leitrim Assessment of Need template and format to ensure accurate information is available to staff.
• The Person in Charge has agreed with nursing staff time frames for the completion of the Assessment of need and this will be closely monitored by the person Charged to be completed by 14/06/2026
• The Person in Charge with the Registered Provider has now a system in place to capture time frames for three-monthly evaluation of the support plans in the assessment of need for all residents in the designated centre.
• A monitoring system has been established through audits and centre's QIP which will be submitted monthly to the Director of Nursing. Completed 05/06/2026

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(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	30/05/2026

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/07/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	14/06/2026