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:	Castleview
Name of provider:	The Rehab Group
Address of centre:	Tipperary
Type of inspection:	Announced
Date of inspection:	18 March 2026
Centre ID:	OSV-0002659
Fieldwork ID:	MON-0041237

About the designated centre

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

Castleview is a designated centre operated The Rehab Group. The designated centre provides community residential services to four adults with a disability. The designated centre consists of two houses located within a close proximity to each other in a town in County Tipperary close to local facilities including shops, pubs, banks and restaurants. The first house is a large detached two-storey house which comprises of three individual resident bedrooms, a sitting room, two activity rooms, a kitchen, dining room, a utility room, a sleepover room, a staff office and a number of bathrooms. The second house is an individualised apartment which comprises of an open plan sitting/dining and kitchen, one bedroom and a bathroom. The staff team consisted of team leaders and care staff. The staff team are supported by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Wednesday 18 March 2026	09:00hrs to 16:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

This was an announced inspection and was completed to inform a registration renewal decision for the designated centre. Overall, inspection findings indicated that residents were very happy living in Castleview. Some improvements were required in the areas of governance and management audits, premises maintenance and safeguarding of residents' finances.

The designated centre comprised of two separate premises and the inspector visited both premises and met with all four residents living in the centre during the course of the day.

The first premises was a large detached two-storey house which comprised of three individual resident bedrooms, a sitting room, two activity rooms, a kitchen, dining room, a utility room, a sleepover room, a staff office and a number of bathrooms. A resident greeted the inspector on arrival to the centre and led a walk around of their house to show the inspector their home. The residents had been made aware of the inspection and a sign announcing the inspection was noted prominently displayed in the centre hallway.

The resident showed the inspector their personal living room where they had toys, pictures and a karaoke machine, they appeared very happy with their home and proud of their personal space. Overall, the house was homely and clean and residents had all personalised their own rooms with pictures and personal belongings. One staff member took time to show the inspector an outdoor covered area where they had developed a go-kart track for residents. The inspector noted some outstanding premises works in this home and this is detailed further under Regulation 17.

The inspector met with two more residents during the walk around the centre. Residents were finishing their breakfast and listening to music. They greeted the inspector and one resident shook hands with the inspector. The atmosphere was calm and relaxed and some residents spoke with the inspector and staff about their plans for the day ahead such as day services, individual activities and a meal out they had planned.

The inspector visit the second house later in the morning. This premises was an individualised apartment which comprised of an open plan sitting/dining and kitchen, one bedroom and a bathroom. The inspector visited this in the afternoon. This was home to one resident and the inspector engaged with the resident living here briefly as they were going out for a drive with a staff member. They appeared happy and comfortable with the staff member supporting them. Their home was well maintained and the resident had a number of sensory items and toys, in line with their individual preferences.

Four residents had completed satisfaction questionnaires as part of the registration renewal process. These all expressed high levels of satisfaction with the service provided in areas such as staffing, their home and living with their peers. There were no complaints communicated with the inspector on the day of inspection.

Residents enjoyed a regular staff team supporting them and staffing numbers during the day and night were found to be in line with the residents' needs. The staff team comprised of support workers. The centre had a full time team leader who held the role of person in charge, in place who was supported by two team leaders. All were regularly present in the designated centre and staff and residents were very familiar with the management team. The centre was also supported by a regional manager. There was a key working system in place and each resident had a key-worker assigned to them. A picture version of the staff rota was noted displayed in the centre hallway for residents to see. The inspector observed kind and familiar interactions between staff and residents throughout the day.

The residents enjoyed regular activation. Some residents attended day services Monday to Friday and other residents enjoyed bespoke wraparound activation schedules. Residents all had individual personal goals in place which had been developed in their annual person centred planning meetings. One resident was decorating their room and was hoping to attend a show in the coming months. Residents regularly engaged with their local communities through meals out, going to the cinema, meeting friends and shopping trips. The inspector noted that residents regular activities included baking, arts and crafts, horse riding and holistic therapies.

The next two sections of the report present the findings of the inspection in relation to the governance and management arrangements in the centre, and how these arrangements affected the quality and safety of residents' care and support.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. The provider had implemented management systems to ensure that the service provided to residents was consistent, and appropriate to their assessed needs. There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre.

The centre was managed by a full-time person in charge, and they were supported in their role by two team leaders. There was a regular core staff team in place and they were very knowledgeable of the needs of the residents. The staffing levels in place in the centre were suitable to meet the assessed needs and number of residents living in the centre. There were some outstanding premises issues in the

centre and the inspector found that oversight systems had not fully captured these issues or addressed them in a timely manner.

Registration Regulation 5: Application for registration or renewal of registration

A full and complete application to renew the registration of the designated centre had been completed by the provider and submitted to the Chief Inspector of Social Services within the requested timelines prior to the centres registration end date.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection the provider had ensured there was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times in line with the statement of purpose. The person in charge effectively managed staff shifts through comprehensive planned and actual rosters. The inspector reviewed both planned and actual staff rosters, which were maintained in the designated centre for the months of December 2025 to April 2026 and found that regular staff were employed, which ensured continuity of care for all residents. Furthermore, all rosters reviewed accurately reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts. Staff team meetings took place monthly and these were attended by the person in charge and team leader.

The inspector reviewed three staff personnel files and found that all Schedule 2 documents were in place for these staff members. While Garda vetting was in place for all staff, re-vetting was overdue for three staff member and this is highlighted further under Regulation 8.

Judgment: Compliant

Regulation 16: Training and staff development

Robust systems were in place for regularly monitoring staff training needs. A review of the staff training matrix confirmed that all staff had completed a comprehensive range of training to ensure they had the necessary knowledge and skills to effectively support residents. This included required training in mandatory areas such as fire safety, manual handling, behaviour management, safeguarding vulnerable adults, medication management, first aid and infection control.

Staff were experiencing regular one-to-one supervision with a line manager every three months, in line with service policy. A clear schedule was in place for this to take place regular until year end.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had ensured that there was an appropriate contract of insurance in place to insure against risks such as loss or damage to the property and injury to the residents. This was submitted to the Chief Inspector as part of the registration renewal process.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a full time person in charge in place who was supported by two team leaders. All were present on the day of inspection and facilitated the inspection day. The person in charge shared their role with two other designated centres and divided their time equally amongst the three designated centres. It was evidenced that there was regular oversight and monitoring of the care and support provided in the designated centre and there was regular management presence within the centre.

The provider and local management team carried out a suite of audits, including audits on residents' finances, medicine, fire safety, health and safety, and infection prevention control (IPC). An unannounced audit was completed every six months by the provider's internal quality lead and this had most recently been completed in November 2025. An annual review of the quality and safety in the designated centre had been completed for the period of September 2024 to September 2025. This had been completed by a senior manager and a copy of the report was made available for the inspector to review.

The inspector found that a number of premises issues had not been fully identified or actioned in this report. There was no time bound plan or no clear time lines identified for the issues to be addressed. The provider had submitted a compliance plan response which had committed to complying with Regulation 17 before November 2025 following the centres most previous inspection in April 2025. This plan had not been adhered to.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The centre had a Statement of Purpose in place which contained all items as set out in Schedule 1 such as a description of the centre, the care and support needs of the residents, the services provided, staffing arrangements and the organisational structure. This was found to be regularly reviewed and accurately reflected the service provided. Additionally, a walk-around of the designated centre confirmed that the statement of purpose accurately reflected the available facilities, including room sizes and their intended functions.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed, care plans, daily notes, restrictive practices and the accidents and incidents log in the centre and found that incidents had been notified to the Chief Inspector within the timelines as required by Regulation 31.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service provided for the residents who lived in the designated centre. The provider had measures in place to ensure that a safe and quality service was delivered to each resident. The findings of this inspection indicated that the provider had the capacity to operate the service in a manner which ensured the delivery of care was safe and person-centred.

The provider had mitigated against the risk of fire in the centre by implementing suitable fire prevention and oversight measures. There were suitable arrangements in place for overall risk management in the centre. However, there were a number of outstanding property maintenance issues and the provider had failed to address these in a timely manner since the centres previous inspection in April 2025 as detailed under Regulation 17. Further actions were also required in the area of safeguarding residents' finances.

Regulation 17: Premises

The designated centre comprised of two separate premises and the inspector visited both premises on the day of inspection.

The first premises was a large detached two-storey house which was home to three individuals. It comprised three individual resident bedrooms, a sitting room, two activity rooms, a kitchen, dining room, a utility room, a sleepover room, a staff office and a number of bathrooms. The second home was an individualised apartment which comprised of an open plan sitting/dining and kitchen, one bedroom and a bathroom. This was home to one resident and the inspector met with them as they were going out for a drive with a staff member.

While overall, the premises presented as clean and homely, there were a number of outstanding maintenance issues that needed to be addressed in the first property visited. These included:

- A collapsed boundary wall to the front of the property. This presented as unsightly at the entrance to the home.
- Areas in the centre requiring varnishing and repainting such as worn and scratched door frames, skirting boards and flooring.
- The kitchen units were noted with surfaces peeling in some areas.
- A rusting vanity mirror was noted in one bathroom.
- Overall septic tank issues for the property which posed a restriction at times on using the outside patio area and a downstairs toilet.

Some of these issues, such as the boundary wall and septic tank, had been identified during the centres most previous inspection in April 2025 and the registered provider had failed to address them in a timely manner. The provider had committed to address these issues and comply with Regulation 17 before November 2025 following the previous inspection. The inspector also found that these premises issues had not been fully actioned with a time bound plan following the provider own internal quality audits.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were clear processes in place for risk management in the designated centre. The centre had a policy in place for risk management and this identified clear systems for hazard identification and assessment of risks throughout the designated centre. Residents had individualised risk assessments in place for areas of potential risks such as falls and manual handling and these were regularly reviewed. Risk assessments included clear control measures to mitigate potential risks. A system was in place for recording any adverse incidents which occurred in the centre. Any

adverse incidents were reviewed by the management team and further action was taken when required to ensure residents were safe.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had mitigated against the risk of fire in the centre by implementing suitable fire prevention and oversight measures. The inspector completed a walk around both premises and noted containment systems, detection systems, fire fighting equipment and emergency lighting. The inspector completed a test on all fire doors in the designated centre and found that these were all closing effectively. The inspector observed that the fire panel was addressable and easily accessed in designated centre and was noted as having no faults on the day of inspection. Staff completed daily fire safety checks in the centre.

In addition, the inspector examined the fire safety records, including fire drill documentation, and confirmed that regular fire drills were conducted in accordance with the provider's established policy every three months. The provider demonstrated that they were capable of safely evacuating residents under both day time and night time conditions. All residents had personal emergency evacuation plans in place (PEEP's)

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the residents' care planning documentation and found that all residents had up-to-date assessments of need and personal plans in place which informed the provision of care and support in the centre. Plans were developed for areas such as physical health, personal care, feeding/eating and drinking, communication, social supports and activation. Some residents required multi-disciplinary supports and any recommendations made by multi-disciplinary healthcare professionals were implemented into the residents plans of care, such as mental health support requirements and communication supports.

The residents enjoyed regular activation. Some residents attended day services Monday to Friday and other residents enjoyed bespoke wraparound activation services. Residents all had individual personal goals in place which had been developed in their annual person centres planning meetings. One resident was decorating their room and was hoping to attend a show in the coming months. Residents regularly engaged with their local communities through meals out, going

to the cinema, meeting friends and shopping trips. Residents were supported to regularly visit family and friends.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were a number of restrictive practices used in the centre. The inspector completed a review of these and found they were the least restrictive possible and used for the least duration possible. Restrictive practices in use had been notified to the Chief Inspector on a quarterly basis in line with the regulations. Additionally, each resident had on file individualised risk assessments with clear rationale for the use of any restrictive practices.

Residents had positive behavioural support plans in place when required and appropriate multidisciplinary professionals were involved in the assessment and development of the evidence-based interventions with the residents in the event of a behavioural expression of need. Staff and management completed trending reports of all incidents of challenging behaviours and these were regularly reviewed and further actions implemented when required.

Judgment: Compliant

Regulation 8: Protection

There were clear systems in place in the centre to safeguard residents. All staff had completed up-to-date training n the safeguarding and protection of vulnerable adults and there was a designated officer identified for the centre to review all safeguarding concerns. The centre had a safeguarding folder in place with management plans to support safeguarding in the centre. The inspector found that any safeguarding incidents which had occurred in the centre had been treated seriously and management had engaged with the appropriate stakeholders and developed individual safeguarding plans when required. Residents had detailed care plans in place to guide staff when supporting them with personal care. Residents all had inventory lists in place to safeguard personal belongings and these were regularly reviewed.

The inspector reviewed financial safeguarding systems in place. Progress had been made in this area since the centre's most previous inspection. Three residents now had full access to their own bank accounts and the provider had oversight of statements when residents required this support. However, one resident did not have full control of their finances and the provider did not have full oversight of their finances to ensure that they were safeguarded. Furthermore, while all staff had

initial Garda-vetting in place, three staff members were found to require re-vetting in line with the providers staff policy.
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 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Castleview OSV-0002659

Inspection ID: MON-0041237

Date of inspection: 18/03/2026

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: • Subsequent to the Annual Review which was completed on 04/09/2025, The Quality & Governance Directorate reviewed and updated the format of the Annual Review Document which was circulated in September 2025. Actions identified during the annual review are now more clearly recorded with timeframes and persons responsible assigned. • The PIC will review progress monthly and will document progress of all actions. This record will be held locally and be available for review and audits. • The current Annual Review dated 04/09/2025 was updated by the current Regional Manager to ensure current actions are in SMART, • All property related actions identified in this report will be addressed by 31/10/2026. • The next annual review is scheduled for September 2026.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The PIC has reviewed all maintenance issues identified during the inspection and has developed a clear plan with assigned responsibilities and completion dates to ensure compliance. • Collapsed boundary wall to the front of the property is due to be repaired by 21/06/2026. • Rusting vanity mirror in bathroom will be replaced by 11/05/2026. • Areas in the centre requiring varnishing and repainting such as worn and scratched	

door frames, skirting boards, and flooring will be addressed by 30/09/2026.
• Kitchen units with noted peeling in some areas will be addressed by 30/09/2026.
• Septic tank issues for the property will be addressed by 31/10/2026.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• The provider continues to communicate with one resident's representative again in relation to opening a bank account in the resident's name. The resident's representative has committed to ensuring this is completed by 08/08/2026.
• PIC has reviewed staff personnel files to ensure that Garda vetting is in place for all staff. Application for re-vetting which was overdue for three staff members at the time of the inspection was completed on 20/05/2026.

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.	Not Compliant	Orange	31/10/2026
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	31/10/2026
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation	Substantially Compliant	Yellow	30/09/2026

	with residents and their representatives.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	08/08/2026