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:	Lakeview House
Name of provider:	Trinity Support and Care Services Limited
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	23 September 2025
Centre ID:	OSV-0008128
Fieldwork ID:	MON-0048018

About the designated centre

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

The centre is a seven day full-time residential community house that according to the centre's statement of purpose, that can provide a home for three adults both male and female with an intellectual disability, autistic spectrum and acquired brain injury and may also have mental health difficulties and behaviours of concern. The centre will provide staff support based on the assessed needs of the residents. The premises is a single story detached house, on its own grounds, and comprises of a communal kitchen/dining, living room, sun room and each resident has an individual bedroom one of which one is en-suite facilities and another has a shower facility. The centre is located near a town within access to services and amenities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	1

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
Tuesday 23 September 2025	10:30hrs to 15:40hrs	Raymond Lynch	Lead
Tuesday 23 September 2025	10:30hrs to 15:40hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

This was a risk-based inspection following up on the compliance plan as submitted to the Office of Chief Inspector after the last inspection of the designated centre on 03 March, 2025. At that inspection Regulation 23: governance and management and Regulation 26: risk management were both assessed as substantially-compliant and, the provider submitted a compliance plan to the Chief Inspector with assurances that the issues as found under both regulations would be addressed. This inspection found that those issues had been largely addressed.

On arrival to the centre the inspectors were met with a staff nurse, a social care worker and the person in charge. The staff nurse explained to the inspectors that the resident was still resting in bed. The resident did not attend any day service and was not in education or employment at this time. The staff nurse explained to the inspectors that the resident decided for themselves what to do each day. For example, on the morning of this inspection, they were attending a general practitioner (GP) appointment and doing some personal shopping. Most days the resident was out and about and, they were on a 2:1 staffing arrangement throughout the day.

One inspector spoke to the resident for 20 minutes prior to their GP visit and social outing. The resident was a ward of court (a person who the courts decided was not able to look after their own affairs and, decisions were made on their behalf by the court or a person appointed by the court). The resident reported that they felt they had no control over their own life and could only make basic decisions with regard to their diet and what social activities to go on each day. They said that they felt they were not being listened to and were not understood when they expressed their feelings. They informed the inspector that they had wanted to go to college this year but was informed that they could not as they would lose her job seekers allowance. Additionally, if they did decide to go to college they would have to attend with two staff members from the service and they did not want this. The resident stated that they had lost all contact with their family and had not seen their brothers this year. They also said that they do not see their cousin or their friend and were very disappointed as they had wanted to go to Scotland this year for their 21st birthday (a trip they had been planning for three years) and this did not happen. Additionally, they wanted to visit their father's grave for his birthday and fathers day but did not get to go.

The resident acknowledged that they had gone camping during the summer with staff and enjoyed this. However, they also said that at 21 years of age they needed more control over their own life as they were 'fed up with people making decision for them'. At the end of the conversation they asked the inspector for their views to be reflected in this report and left the centre to attend a GP visit and to go on an outing with staff.

The inspectors spoke with the person in charge about the resident having more control over their own life. They said that the resident had access to an independent advocate in the past but had since been discharged. The also said that at this time, the resident was on a waiting list to access independent advocacy services and, they were involved in the on-going court case regarding their wardship.

Every multi-disciplinary team meeting was discussed with the resident and, the resident had access to a guardian ad litem (a person appointed to represent the views of the resident and ensure that their voice was heard by the Court).

Additionally, the person in charge also informed the inspectors that they had support from members of an inter-agency team who were aware of the safeguarding issues and ongoing risks the resident could present with. This team discussed these issues and progress made with the resident. The overall aim was to take a multi disciplinary approach to decision making and, agree a way forward taking into account the resident's will and preference and the need for the resident to be safe. This team consisted of senior management personnel from the agency's funders, the resident's guardian ad litem (as identified above), a member of the national safeguarding team, a psychologist and the person in charge. The person in charge informed the inspectors that these team meetings took place every second week.

The house was observed to be clean, warm and welcoming on the day of this inspection and comprised of a large kitchen cum dining room/TV room, a separate sitting room, a sun room and bathroom. The resident had their own ensuite bedroom which was decorated to their individual style and preference.

Staff were observed to be kind, caring, patient and person centred in their interactions with the resident and the resident appeared comfortable in the company and presence of staff.

The person in charge was found to have systems in place for the local oversight and management of the centre. They maintained files, documentation and rosters as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations). The had a very good knowledge of the assessed needs of the resident and were found to be responsive to the inspection process.

The next two section of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements impacted the quality of care and support being provided to residents.

Capacity and capability

While the resident expressed dissatisfaction with aspects of their current placement, systems were in place to meet their assessed needs and there were clear lines of

authority and accountability in the service. However, aspects of the staffing arrangements and complaints process required review.

The person in charge was a qualified nursing professional, had good oversight of the service and systems in place for the supervision of their staff team.

The skill mix of staff and the number of staff on duty each day was as required to meet the assessed needs of the resident. However, the service was operating with a gap of one team leader and this needed review.

Training had been provided to staff to ensure they had the necessary skills to support the residents.

While there were no open complaints on file at the time of this inspection, as aspect of the complaints process required review.

Regulation 14: Persons in charge

The person in charge met the criteria for the role of person in charge as set out in S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations).

They were an experienced and qualified nursing professional and had completed a post-graduate qualification in a relevant discipline. They also held an additional qualification in leadership, quality and management.

The worked in the centre Monday to Friday of each week and had systems in place for the oversight of the service and for the supervision of their staff team.

The also demonstrated a commitment to providing person-centred care to the resident. For example, the person in charge told the inspectors that they were aware that the resident felt disempowered in the service however, they advocated for them at various meetings ensuring their voice was represented. They also said however, that they had a duty of care to ensure the resident's safety.

For example, they explained to the inspectors that the resident had requested a change with regard to their prescribed times for taking their morning medications. In order to facilitate this request so as to respect the will and preference of the resident and in order to ensure it was safe for the resident to make this decision, the person in charge arranged for them to have a consultation with their GP. This consultation was to review and change the times they took their morning medications with support, advice and guidance from their GP. This GP appointment was facilitated on the morning of this inspection.

The person in charge al ensured that the decisions the day-to-day resident did make for themselves (such as what outings to go on and weekly meal planners) were respected and supported by the staff team.

Judgment: Compliant

Regulation 15: Staffing

The staff team comprised of full-time person in charge, a team lead (who was a staff nurse), a team of social care workers and assistant social care workers.

The staffing arrangements were as described by the person in charge on the day of this inspection. For example:

- two staff worked each day in the centre and,
- two staff covered night duty (one worked live night duty and the other worked on a sleep over arrangement)
- the person in charge worked Monday through to Friday each week.

One inspector viewed the rosters from 01 September 2025 to 28 September 2025 and found that all shifts had been covered for this month in line with the above arrangements.

It was observed however, that at the time of this inspection the centre was operating with a shortfall of one team lead and this required review. This was because the team leader was responsible for providing guidance and support to the staff team and for ensuring the needs of the resident were provided for, when the person in charge was off duty at weekends or when they were on leave.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with the training to meet the assessed needs of the residents. For example, according to the training matrix presented to the inspectors on the day of this inspection, staff had training in the following:

- Children's First
- safeguarding
- fire safety
- first aid
- manual handling
- medication management (to include the administration of rescue medication)
- risk assessment

- restrictive practices
- positive behavioural support
- autism
- mental health
- diabetes
- ligature training (to include ligature cutting)
- self harm
- behaviours that challenge
- crisis prevention
- infection prevention and control (IPC).

It was observed that one staff had to undertake training in crisis intervention however, the person in charge was aware of this and had a plan in place to address it. They also assured the inspectors that there was always a staff member present in the centre who had this training.

The inspector asked to view safeguarding certificates of three staff members who worked in the centre and the person in charge was able to retrieve these documents immediately. Additionally, these three staff members also had certificates for training in ligature cutting for on file.

The person in charge assured the inspector that agency staff working in centre also had training as required. The inspector looked at one agency staff file and saw that they had certificates of training completed in cardiac first aid, fire safety, manual handling and safeguarding. Additionally, they also had appropriate vetting on file.

It was observed that some of the newer staff members did not complete sexuality and relationship training. This training was provided to staff in the past as at that time, it was relevant to the resident living in the centre. However, at the time of this inspection, it had been discontinued for newer staff commencing work in the centre. Taking into account the fact that the resident had recently expressed interest in developing a relationship this decision required review. The person in charge said that they would review this decision and if required, would ensure this training would be provided to staff going forward.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre had effective leadership, governance and management arrangements in place with clear lines of accountability and accountability. It was led by an experienced and qualified person in charge who was supported in their role by a director of operations and a member of the quality management team. There was also a management on-call system in place to provide support to staff if or when required.

The person in charge assured the inspectors that the service was being audited as required by the Regulations and, the issues that were found in the previous inspection of the service on 03 March 2025, had been addressed.

For example:

- the last inspection found that staff were not availing of the management on call system in times of serious adverse incidents occurring out of hours. The inspectors saw evidence that staff were now contacting management on call (and where required a doctor on call) when they needed advice and support out of hours
- an issue to do with the resident having access to the service computer and staff rosters had been addressed since the last inspection. The inspectors saw on this inspection that the resident now had their own personal computer.
- the person in charge was keeping the quality enhancement plan under regular review and was ensuring actions identified on this audit were being addressed (or a time frame was in place so as to ensure that they would be addressed).

On reviewing the quality enhancement plan on the day of this inspection, the inspectors observed that this document identified a number of areas that required addressing in the centre. For example:

- restrictive practices required review
- the training matrix required review
- the statement of purpose required updating
- some furniture required repair and or replacing
- a room required cleaning.

All this issues had been addressed at the time of this inspection.

The person in charge also had systems in place so as to support their staff team raise a concern (if they had one) about any aspect of the quality or safety of care provided in the centre. For example one staff member spoken with by an inspector reported that they would have no concerns discussing any issue (if they had one) to the person in charge.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was aware of their legal remit to notify the Chief Inspector of any adverse incident occurring in the centre as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations).

Judgment: Compliant

Regulation 34: Complaints procedure

The inspectors observed that there were currently no complaints on file for the service at the time of this inspection however, one aspect of the complaints procedures required review.

One inspector reviewed four complaints that had been made in 2025 about staff members by the resident. While each complaint was logged in the centre and investigated, there was inadequate information on the actual outcome of the complaint and these complaints were not signed off.

This meant that the inspector could not determine if the resident was satisfied with the outcome of the complaint or satisfied with the way in which the complaint was dealt with.

Judgment: Substantially compliant

Quality and safety

As identified above, the resident expressed dissatisfaction with aspects of service as they felt disempowered by not being able to make their own decisions. This was discussed in section 1 of this report, What residents told us and what inspectors observed and under Regulation 13: general welfare and development, below.

However, it was observed that they were supported with their healthcare and emotional needs and, had access to allied health professionals. For example, the resident had access to GP services and support from psychology and mental health professionals as required. Additionally, care plans and behavioural support plans were in place to guide staff practice.

Systems were in place to mange risk and to safeguard the resident in the centre. Additionally, systems were in place to support the resident with their medication needs.

Regulation 13: General welfare and development

As discussed in section1 of this report, '*What residents told us and what inspectors observed*' the resident was a ward of court and reported to one of the inspectors

that they were not happy with aspects of the service as they had limited opportunity to make their own decisions. They felt that at 21 years of age, they should more control and autonomy over their own lives.

They also informed the inspector that they had wanted to go to college this year but was informed that they could not as they would lose their job seekers allowance. Additionally, if they did decide to go to college they would have to attend with two staff members from the service and they did not want this.

The resident stated that they had lost all contact with their family and had not seen their brothers this year. They also said that they do not see their cousin or their friend and were very disappointed as they had wanted to go to Scotland this year for their 21st birthday (a trip they had been planning for three years) and this did not happen. Additionally, they wanted to visit their father's grave for his birthday and fathers day but did not get to go.

While some of these issues were out of the control of the service and a number of restrictive practices were in place to ensure their safety, it was important that the service continued to advocate on the residents behalf so as to ensure their voice was heard in the process (this issue is further discussed and explained under Regulation 8: protection).

However, as the resident felt that the only decisions they could make was what outings to go on and what food to eat each day, the service needed to complete an in depth review the residents current daily routine. This could help identify additional and or new social or recreational opportunities that the resident might like to engage in turn, could help enhance their overall mental health and general well-being.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Systems, policies and procedures were in place for the management and review of risk so as to support the residents safety in the centre and the issues as identified on the last inspection of this service on 03 March 2025, had been addressed.

The resident presented with a number of significant risks and individual risk assessments and restrictive practices were in place to help mitigate such risks. For example, where the resident was at risk of self-harm the following controls were in place to support their safety:

- their bedroom had anti-ligature furnishings
- the only used plastic cups while in the privacy of their own bedroom
- the resident was not permitted drink from aluminium cans without supervision

- the resident was on 2:1 staffing each day (and was accompanied by 2 staff on all social outings)
- educational work was being done with the resident
- staff had training in risk reduction and ligature cutting
- a ligature cutters was brought on all social outings
- the resident had access to mental health and behavioural specialists
- the resident had a positive behavioural support plan in place
- staff had training in positive behavioural support.

It was observed that on 10 September 2025, the resident had expressed suicidal intent and allegedly had sharp objects, medicines and alcohol in their room. This was reported to the Chief Inspector by the person in charge. Following that report the service confirmed via email that there were no identified items in the residents room that presented an immediate risk of harm. Additionally, the person in charge ensured that visual checks were conducted twice daily in the room as were searches by two staff member and, there had been no other items found during these checks. The person in charge had also updated the resident's individual risk assessment to ensure that staff conducted room searches twice daily so as to ensure there were no sharp objects concealed in the bedroom that the resident could use to self-harm.

The person in charge informed the inspectors that it was unclear at this stage as to how the resident got these items into their room and at the time of this inspection, this remained under investigation.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Systems were in place for the ordering, storing, administering and return of medicines in the centre.

A self-administration assessment was conducted with the resident on 05 September 2025 which determined the resident needed staff support with taking their medication.

The resident had medication administration guidelines (support plan) in place so as to guide staff on the safe administration of their medication. These guidelines were reviewed by the person in charge (who was a qualified nursing professional) on 20 August, 2025.

The resident could regularly refuse to take their medication and a risk assessment was in place to manage this issue. This assessment was reviewed by the person in charge on 08 August, 2025. The person in charge also kept oversight of this issue and kept a medication refusal log so as the dates and times the resident refused their medication, were on record.

Additionally, the person in charge had arranged for the resident to attend their GP on 23 September, 2025 so as to discuss and review their medication.

Education was also provided to the resident on the importance to taking their medication as prescribed by health care professionals

Judgment: Compliant

Regulation 6: Health care

Systems were in place to meet the assessed healthcare needs of the resident. For example, the resident has access to the following services:

- GP services
- dietitian
- nutritionist
- optician
- doctor on call services.

Health action plans were also in place to guide practice. As identified under Regulation29: Medicines and pharmaceutical services, the resident at times could refuse to take their medication or follow healthcare professionals guidelines. However, their GP was aware of this and an educational piece has been completed with the resident about the importance of adhering to healthcare guidelines and taking medication as prescribed. On the day of this inspection the resident had planned a visit to their GP to discuss their medication and to request a change in time for taking their morning medicines.

Hospital appointments were facilitated as needed. For example, recently the resident's blood sugar levels were recorded as being too high and staff rang the on call system for advice. They were advised by on call management to take the resident to hospital for review. The resident was taken to the nearest hospital where they were reviewed and held until their blood sugar levels had reduced to a acceptable level. The resident informed the doctor that they may have skipped some of their required medication and the doctor explained to the resident that it was important that they always took their medication as prescribed.

Judgment: Compliant

Regulation 7: Positive behavioural support

The resident had access to mental health supports to include psychology and behavioural support.

They also had a positive behavioural support plan in place. The purpose of this plan was to improve the resident's overall quality of life by recognising and resolving the underlying reasons for challenging behaviours. The plan identified triggers for challenging behaviour and strategies for staff to take, so as to manage such behaviours.

The plan had recently been updated and reviewed on 08 August 2025 however, it was observed that the psychologist has not signed of on this review and update. When this was brought to the attention of the person in charge, they said they would ensure this plan would be signed off.

Judgment: Compliant

Regulation 8: Protection

Policies, procedures and systems were in place to safeguard the resident living in this designated centre.

At the time of this inspection there was one active safeguarding plan in place (this safeguarding issue was discussed under Regulation 26: risk management procedures). The issue had been reported to the designated safeguarding lead, the national safeguarding team and the Office of Chief Inspector and, a interim safeguarding plan had been put in place.

Additionally, the person in charge also had support from members of an inter-agency team who were aware of the safeguarding issues and ongoing risks the resident could present with. This team discussed these issues and progress made with the resident. The overall aim was to take a multi disciplinary approach to decision making and, agree a way forward taking into account the resident's will and preference and the need for the resident to be safe. This team consisted of senior management personnel from the agency's funders, the resident's guardian ad litem (a person appointed to represent the views of the resident and ensure that their voice was heard by the Court), a member of the national safeguarding team, a psychologist and the person in charge. The person in charge informed the inspectors that this team meet every second week.

Additionally, the inspectors noted the following:

- staff had training in safeguarding and Children's First
- one staff spoken with said they would have no issue reporting a concern (if they had one) about the quality or safety of care to the person
- the resident was provided with 2:1 staff support at all time

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Lakeview House OSV-0008128

Inspection ID: MON-0048018

Date of inspection: 23/09/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider has initiated the recruitment for the vacant Team Leader post. It is expected this post will be filled by 15 January 2026. The Team Leader vacancy is currently being backfilled by a shift leader, who has been deemed competent in the absence Person in Charge.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The four complaints that were been made in 2025 regarding staff members have been reviewed by the Person in Charge, these have now been signed off. As part of the Clinical Quality Assurance Managers role, who is also the Complaints Officer, the Complaints folder will be reviewed during their visits.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development:	

Actions Taken / To Be Taken:

A review meeting with the relevant stakeholders, including the resident's legal representatives and multidisciplinary team and the resident will be put forward as specific agenda items at the next interagency meeting 5 November 2025, to explore options for supporting the resident's expressed wishes such as attending college, reconnecting with family and friends, and participating in significant personal events.

The Person In Charge and Psychology Team will review all restrictive practices in place to ensure they remain proportionate, necessary, and in the best interest of the resident, with a view to reducing restrictions where possible by 30 October 2025.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/11/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	15/01/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person	Substantially Compliant	Yellow	30/10/2025

	maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			