Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Belmont House Private Nursing Home
Name of provider:	Belmont Care Limited
Address of centre:	Galloping Green, Stillorgan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	22 December 2025
Centre ID:	OSV-0000014
Fieldwork ID:	MON-0049250

About the designated centre

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

Belmont House is a 156-bed centre providing residential, respite and short-stay convalescent care services to male and female residents over the age of 18 years. The centre was originally a Georgian country house and was owned by a religious order. The building has been extended and completely refurbished while retaining some of its older features. It is located on the Stillorgan dual carriageway, close to the village of Stillorgan, with access to local amenities, including shopping centres, restaurants, libraries, public parks and coffee shops and good access to public transport. Accommodation for residents is across five floors. There are also areas for residents to socialise and relax, including activity rooms, a coffee dock and quiet areas. The majority of bedrooms are single rooms, and there are 25 twin rooms. There is 24-hour nursing care with access to both in-house and specialist healthcare as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	125

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 22 December 2025	08:15hrs to 13:45hrs	Aoife Byrne	Lead
Monday 22 December 2025	08:15hrs to 13:45hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

Residents living in Belmont House Private Nursing Home told inspectors that it was a pleasant place to live. The majority of residents expressed satisfaction with their living conditions and highlighted the kindness of the staff. One resident said "it's a wonderful place to live and the staff are like friends", while another resident said "I couldn't be living in a nicer nursing home".

Two inspectors arrived unannounced at the centre during the morning time. This inspection was scheduled following receipt of solicited information, to ensure that the provider had taken appropriate action following the emergency closure of the kitchen, and to ensure that this did not impact the residents living in the centre.

On arrival, inspectors were met by the person in charge and prior to the introductory meeting inspectors visited the piano room which was set up as a temporary kitchen, while emergency maintenance works were being carried out in the main kitchen. Inspectors spoke with catering staff in relation to the plans and processes in place to ensure residents received their meals in a timely and appropriate manner. Inspectors were informed that as a result of the emergency closure of the kitchen the lunch and evening meals were now being prepared off-site and transported to the centre. The catering staff and some care assistants then served the food to the residents as normal. The catering staff described to the inspectors the process in place to ensure that all residents' dietary and nutritional needs were met.

Inspectors walked through the centre and observed that the atmosphere was relaxed and calm. Some residents were mobilising independently around the centre, while others were being assisted by staff to get ready to start their day. Other residents remained in bed with signs on their door requesting they were not disturbed until later in the morning. A warning sign indicating a risk of infection was displayed on the door of one bedroom, this also had a picture of a yellow hazardous chemical symbol. There was also a trolley containing personal protective equipment (PPE) positioned on the corridor outside the room, partially obstructing the walkway. Staff informed inspectors that the resident did not have a confirmed infection and that the signage and equipment had been placed as a precautionary measure. The potential impact on the residents' privacy and dignity was discussed with management and the signage was removed immediately. Alternative arrangements were implemented for the storage of the PPE required by staff.

Inspectors took the opportunity to speak with staff. Some raised concerns in relation to the staffing levels, specifically the ratio of staff to residents who had high dependency needs. Staff told inspectors that staffing levels had been an issue, with occasions where absences were not replaced and staff were asked to move and work on different floors where they are not familiar with the residents.

There were 125 residents living in the centre on the day of inspection. The design and layout of the premises met the individual and communal needs of the residents. The centre was visibly clean and bright on the day of the inspection with Christmas decorations displayed in the main communal areas. The coffee shop area on the ground floor was bustling with residents meeting their visitors throughout the day.

Inspectors met with many residents and visitors to gain insight into their experience of living in the centre and the new catering arrangements in place, and had in-depth conversations with four visitors and 10 residents. While the majority of the residents spoke highly of the staff and said they were prompt to respond to their needs, one resident was observed by the inspectors to wait over 10 minutes for their call bell to be answered. This resident told inspectors that staff were not always quick to respond to their call-bell; inspectors were required to locate staff and request they attend to the resident. Management were informed of this following the walk around. Another resident told inspectors that sometimes they can be waiting up to 25 minutes for staff to assist them.

There was an activity schedule on display on each unit, however inspectors were told that changes had been made to the schedule and a choir was due in the centre on the morning of the inspection. The schedules on each unit had not been updated and while staff were informed of the changes not all residents had the opportunity to attend.

Residents who spoke with inspectors spoke highly of the food and said they had not noticed any difference since the kitchen closed. One resident said that the 'food is actually nicer'. The inspectors observed the lunch time experience on the day of inspection, tables were set with table cloths, cutlery, condiments and a vase with flowers. The menus were displayed, and residents were offered a choice of water, milk or juice. Meals were kept hot on each unit in a hot trolley. The meal time experience was seen to be a social occasion for residents, who were observed chatting together. Interactions between staff and residents were observed to be kind and respectful, with staff asking the residents their preferences. However, one resident told inspectors the food was cold the previous day and one resident expressed dissatisfaction with the food they have received over the previous two days. The management team who were on-site met with these residents and responded immediately to the resident's requests. The management team told inspectors that they had reviewed the process and additional actions had been taken to ensure that the food was hot when served to residents.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced risk inspection which occurred following receipt of solicited and unsolicited information. The purpose of the inspection was to ensure the residents were safe and receiving an appropriate standard of quality care and to assess the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended).

Belmont House Private Nursing Home is operated by Belmont Care Limited who is the registered provider of the designated centre, which is part of the Emeis Group. The person in charge reported to a regional director, who was available to provide support on a daily basis for consultation and they attended the centre at a minimum of once per week. The person in charge was also supported in their role by three assistant directors of nursing (ADONs) and five Clinical Nurse Managers (CNMs) and a team of registered nurses, healthcare assistants, catering, maintenance, domestic and activities staff.

Two regional directors, the person in charge and one ADON were present during the inspection and all demonstrated a good understanding of their roles and responsibilities. They were very responsive to any requests for information required on the day of inspection and showed a commitment to addressing areas for improvement. The management team had recently completed an internal audit in the centre which identified concerns in the areas of care planning and assessments, particularly around pressure area care and skin integrity. Further review into these areas were planned to commence following the inspection.

While there was an adequate number of staff working in the centre on the day of the inspection, inspectors found that the oversight of staff allocations and care supervision was insufficient to ensure timely and effective care provision to all residents. The management team on-site told inspectors that they were reviewing the allocations of staff and were aware that further review was required in this area to ensure the correct allocation of staff to meet the dependency needs of the residents, following concerns received by staff in relation to this . On the day of inspection, there were two vacant chef positions and two vacant healthcare assistant positions, and there was an active recruitment campaign for these positions. In the interim, the management team told inspectors that catering managers were providing cover for the chef roles, and existing staff were used to back-fill any gaps in the healthcare assistant rosters.

There was evidence of communication with residents, their families and staff in relation to the emergency works required in the kitchen. Daily meetings were held with staff to provide updates and management were on-site daily to provide oversight and support to staff. Systems and processes were put in place to minimise any impact of the changes in the kitchen to residents.

There was a complaints procedure in place and this was displayed in prominent areas in the centre. Staff, residents and visitors knew who to make a complaint to should they have any. Inspectors reviewed a sample of seven open complaints and four closed complaints. Not all complaints reviewed by the inspectors had been

managed in line with the regulations. This is further discussed under Regulation 34: Complaints.

Regulation 15: Staffing

While there was a sufficient number of staff on duty on the day of the inspection, inspectors observed delays in staff responding to residents' requests for assistance consistent with the feedback shared by some residents. This impacted the quality of care provided to residents and is addressed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the arrangements in place to address deficits in the management of the centre identified following a recent audit completed by the registered provider, a further strengthening of the management systems in place was required to ensure that the service provided was safe, appropriate, consistent and effectively monitored and supervised. For example the registered provider

- did not ensure timely recognition and response to a residents deteriorating health care needs
- had not identified or taken action to address the issues raised by staff and residents about the delay in staff responding to residents' calls for assistance in a timely manner.
- had not adhered to a previous commitment to ensure that all residents' care plans were up-to-date and accurate. Compliance plans submitted following inspections in July 2024, February 2025 and July 2025 committed to addressing this issue. However as per previous inspections some care plans were still not updated and continued to contain historical information meaning it was difficult to determine what information was relevant to the resident's current needs.
- Oversight systems had not identified gaps in the complaints process and taken action to ensure that all complaints were managed as required by the regulations, specifically complaints received by staff members.
- Oversight systems had not identified or taken action to ensure that all notifications required to be submitted to the Chief inspector of Social Services were submitted within the required timeframe of two days.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre was maintained. However,10 incidents were not notified to the Chief Inspector within the regulatory two day time frame.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a nominated complaints and review officer with a clearly outlined complaints process for the centre. However, a review of a sample of open and closed complaints found that not all complaints were managed in line with the regulatory requirements. For example;

- Five complaints did not have a written response informing the complainant whether or not their complaint had been upheld.
- There was no evidence that the complaints received had the outcome of the investigation recorded, the actions taken on foot of the complaint, or the details of reviews requested.
- Staff complaints were not managed in the same manner as residents and family complaints.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that residents were supported by a dedicated team of staff to enjoy a good quality of life. While staff were observed to be kind and attentive to residents, inspectors also observed and were told by residents and staff of times when residents had to wait for long periods of time for assistance.

Although there had been recent changes to the storage and preparation of the food on-site following the closure of the kitchen, this did not appear to greatly impact on the residents. Inspectors observed the lunch serving, which was seen to be calm and organised. There was an appropriate number of staff to assist residents with their meals and residents were seen to be offered a choice with their food and drink. Food was delivered to each unit in a hot trolley where it was maintained at an appropriate temperature. Residents who attended the dining room for their meals were observed to use this as a social occasion where they chatted and conversed

with other residents. Menus for the week were planned and included Christmas pudding and mince pies.

Residents' records were maintained on an electronic system. Inspectors reviewed a sample of residents' assessments and care plans. There was evidence that a comprehensive assessment was carried out for residents before, or on their admission to the centre, and that a care plan was initiated for residents within 48 hours of admission. However, similar to the findings of the past three insections, inspectors found care plans that were not person-centred and had not been updated to reflect residents' current needs, therefore they did not effectively guide staff on the care required.

Residents were facilitated with timely access to general practitioner (GP) services as required or requested. Where residents were assessed as requiring additional health and social care professional expertise, there was a system of referral in place.

There was an up-to-date risk management policy in place and processes in place for identifying, recording and investigating serious incidents. Inspectors observed the risks relating to the closure of the kitchen were included in the centre's risk register, and the action plan for managing catering within the centre was submitted to the inspectors following the inspection.

The activities co-ordinator was on-site and had developed an activities schedule which ensured that the residents had access to meaningful activities which ensured their social and recreational needs were met. Various festive activities had been organised, and on the day of the inspection a choir visited the residents to sing Christmas carols. However, this was a short notice change to the schedule, and although each unit was informed of the change, not all residents were facilitated to attend the activity. This is further discussed under Regulation 9: Residents rights.

Regulation 18: Food and nutrition

Despite some concerns raised regarding the quality of the food served following the emergency closure of the kitchen, the processes put in place to mitigate the risk and impact of this on residents was observed by inspectors to be effective.

Residents continued to have access to snacks, a fresh supply of drinking water and a choice at mealtimes. Food served was wholesome and nutritious and met the dietary needs of the residents. There was adequate number of staff available at mealtimes to assist residents.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place in the centre which included information on identifying hazards and assessment of risk within the centre. There were measures and actions in place to control the specified risks identified in the regulations. There was evidence of a sufficient plan in place to respond to the serious disruption the recent closure of the kitchen had on the centre.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of individual assessments and care plans. Not all care plans were updated to contain the relevant information to facilitate staff to meet the needs of the residents. For example:

- Care plans were in place for residents' rights, infectious processes and psychological well being for all residents whose records were reviewed. However, these were generic and contained the same information, and did not reflect residents' individual assessed needs.
- The continence assessment for one resident detailed the type and size of continence product required. However, the elimination care plan documented different products. Therefore, care plans were not informed by assessments and it was unclear whether the correct continence product was being used for the resident.
- One resident had a safeguarding care plan in place, however, there was no identified or assessed need for the safeguarding care plan.
- A mobility care plan and skin integrity care plan included historical information from September 2024, that was no longer relevant to the resident's current care needs. This could cause confusion in respect of the appropriate interventions for the resident at the time of inspection.

This is a repeat finding from the previous three inspections.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to appropriate medical and health and social care professional support to meet their needs.

Services such as physiotherapy, speech and language therapy, occupational therapy, tissue viability nursing expertise and dietitian services were available to residents through a system of referral.

Judgment: Compliant

Regulation 9: Residents' rights

There were a range of activities for residents to engage in the centre, however due to changes in the activity schedule not all residents had the opportunity to participate in the activities offered. For example: Residents on Maple unit were not facilitated to enjoy the choir who came to visit the centre on the day of the inspection due to staff confusion regarding the change in activity schedule.

While residents were supported to exercise choice in their daily lives and had access to facilities for occupation and recreation, not all areas of the designated centre were accessible to residents should they choose to. For example: the fifth floor library balcony area was only accessible using a pin code, the inspectors were told that only the nurse had access to the code to open the door, which meant that residents had to ask permission and could not use a dedicated communal areas independently.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Belmont House Private Nursing Home OSV-0000014

Inspection ID: MON-0049250

Date of inspection: 22/12/2025

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

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

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

A new report is now being accessed daily from our electronic record system to assist in a full review of residents including those deteriorating. This is a discussion point for daily meetings to ensure escalation of deteriorating health needs. In place 5/02/2026

Management team are receiving coaching in effective supervision with particular focus on staff response times. Weekly call bell audits are being completed to ensure robust actions and learnings. In place 5/02/2026

Care plan and audit training will be completed for all managers and nurses to review all care plans and assessment. Training will be completed by the Regional Director and they will also provide oversight of this action, to be completed by the 20/03/2026

Complaints training has been completed with all ADONs and coaching has been completed with the PIC- complete.

Staff training on managing complaints will be completed by 20/03/2026

A new checklist for complaints management has been implemented to ensure no gaps in this area- completed.

Staff complaints are now being documented onto our electronic recording system to ensure all complaints are managed as per policy- complete and ongoing

Using the daily handover tool and daily meetings, regulatory notifications will be captured in a timely manner to ensure correct timelines are adhered to. Enhanced training will also be delivered to the management team by the Regional Director. This will be completed

by the 28/02/2026

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Using the daily handover tool and daily meetings, notifications will be captured in a timely manner to ensure correct timelines are adhered to. Enhanced training will also be delivered to the management team by the Regional Director. This will be completed by the 28/02/2026

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints training has been completed with all ADONs and coaching has been completed with the PIC- complete.

Staff training on managing complaints will be completed by 20/03/2026

A new checklist for complaints management has been implemented to ensure no gaps in this area- completed.

Staff complaints are now being documented onto our electronic recording system to ensure all complaints are managed as per policy- complete and ongoing
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Regulation 5: Individual assessment and care plan	Not Compliant

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

Care plan and audit training will be completed for all managers and nurses to review all care plans and assessment. Training will be completed by the Regional Director and they will also provide oversight of this action, to be completed by the 20/03/2026

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Activity lead will liaise directly with unit staff on the day of visiting events to ensure residents who wish to attend are facilitated, the activity calendar will be updated with any changes. In place 5/02/2026

Staff will be educated on their responsibility to facilitate residents' participation in activities, including those held off the unit, where residents express an interest. This will be monitored daily by the management team increasing supervision on the floor this will be evidenced on the daily walk around form. In place 5/02/2026

Resident preferences regarding activities are being reviewed and documented to ensure inclusion by the Activity Lead Person, completion by 28/02/2026.

The notice for the 5th floor outdoor space has been updated to ensure all staff have the access code and can enable entry to the balcony at any time. A risk assessment has been completed.

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 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	20/03/2026
Regulation 23(2)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	20/03/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give	Not Compliant	Orange	28/02/2026

	the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	20/02/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	20/02/2026
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Not Compliant	Orange	20/02/2026

Regulation 34(2)(g)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as appropriate, in the event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.	Not Compliant	Orange	20/02/2026
Regulation 34(3)	The registered provider shall take such steps as are reasonable to give effect as soon as possible and to the greatest extent practicable to any improvements recommended by a complaints or review officer.	Not Compliant	Orange	20/02/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested	Not Compliant	Orange	20/02/2026

	and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	20/03/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	20/03/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	28/02/2026

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	28/02/2026