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:	Blossomville
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	13 June 2025
Centre ID:	OSV-0001822
Fieldwork ID:	MON-0045916

About the designated centre

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

Blossomville is a purpose built single storey bungalow located in a town. The centre comprises of six bedrooms, two sitting rooms, a kitchen-dining room, a utility room, a staff office and bathroom facilities. The centre has a maximum capacity of six residents and can provide full-time residential care to residents with intellectual disabilities and /or autism who present with behaviour that challenges and additional needs. Both male and female residents over the age of eighteen years can reside in the centre. The staff team comprises of a person in charge, social care workers, nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Friday 13 June 2025	07:20hrs to 16:55hrs	Conor Dennehy	Lead
Friday 13 June 2025	07:20hrs to 16:55hrs	Lisa Redmond	Support

What residents told us and what inspectors observed

Six residents were living in this centre with inspectors meeting all six of these residents during the course of the inspection. Some of these residents did not interact significantly with inspectors but inspectors did get opportunities to speak with staff about residents in the centre, to observe residents in their environments and to observe the operations of the centre.

Inspectors commenced the inspection early in the morning with a view to speaking some members of night staff before they went off shift. When the inspectors arrived to commence, only one resident was up at the time with the other residents still in bed. This resident said hello to one of the inspectors at this time. During a brief premises walk around, it was observed that the door of another resident's bedroom was left open with staff later indicating that this was by choice of the resident and because of their epilepsy. After this walk around, one inspector spoke with some individual staff in private while another inspector remained in communal areas observing practices including residents being provided with breakfast (observations around this are detailed later in the report). Soon after the inspection commenced, the night staff went off shift and were replaced by the day staff with one of these staff heard to greet the resident that was up.

Later on in the morning, an introduction meeting with a member of management was held after they arrived to the centre. While this was ongoing a loud alarm sounded in the centre. Given the loudness of the alarm both inspectors assumed this alarm to be the centre's fire alarm and went to the centre's front door for the purposes of an evacuation. One of the residents also joined inspectors at the front door at this time. It was noted though that the centre's front door (which was locked via a keypad) did not automatically open. Very shortly after, this alarm stopped with inspectors informed that this alarm was the bathroom alarm for assistance that had been accidentally activated and not the fire alarm. Staff members were observed explaining to the resident who came to the front door that they did not need to evacuate and apologised to them.

After the alarm had stopped, an inspector went to return to the introduction meeting but on his way there, he was greeted by a resident in the centre's larger sitting room. This resident shook the inspector's hand and then said that they had fallen. When the inspector asked if the resident was feeling okay, the resident responded by saying yes before telling the inspector that it was a good day to do silage. Another resident was present in the larger sitting room at this time but did not respond when greeted by the inspector. This resident was observed to spend much of the day in the same location but some instances were observed where staff offered the resident a walk or tried to engage them in a game.

Upon the completion of the introduction meeting, both inspectors were present in the smaller sitting room when a resident entered but did not engage verbally with inspectors. A member of management encouraged the resident to for a drive with

this resident then leaving the centre with two other residents and members of staff via the centre's one dedicated vehicle. These residents did not return to the centre until the early afternoon. Of the remaining three residents, two residents spent much of the rest of the morning in the larger sitting room while, after they had gotten up, the third resident moved between the larger sitting room and the smaller sitting room.

One of the inspectors sat out in the larger sitting room during this time and observed the following:

- Staff attempted to engage with residents in some table tops of activities and games (including a bag toss game) with one resident appearing more engaged in these than other residents.
- Two residents were asked if they wanted a cup of tea with both residents accepting and going to the kitchen-dining room for same before returning to the larger sitting room.
- One resident was asked by staff on multiple occasions if they wanted to go for a walk but the resident declined on each occasion. At one point, a staff member suggested that the resident be offered a drive but another staff member said that this was not possible as the centre's one dedicated vehicle was away from the centre at the time.
- Another resident who moved between the larger sitting room and the smaller sitting room, sat down briefly in the larger sitting room at times. During such instances, some liquid was visible on the resident's face with staff cleaning this off.
- One of the residents received a visit from a family member in the early afternoon. As this visit took place in the larger sitting room, the inspector left the room as this visit commenced.

Not long after this period of observations, the three residents who had earlier left the centre to go for a drive returned. Lunch was then provided for residents with an inspector observing the meal-time experience. Again observations around this are reflected elsewhere in this report. As the inspection entered its final hours, one of the inspector spent some time in the main hall area of the centre. During this time the following was observed:

- One resident moved between their bedroom and the larger sitting room. On one occasion while moving between these rooms, the resident said hello to the inspector and indicated that they were good when asked by the inspector.
- One resident was seen sitting out in a patio area to the rear of the centre with a staff member present.
- At one point, a different resident approach the inspector and made a pointing gesture which the inspector took to mean that the resident was looking for something. The inspector alerted a staff member to this with this staff indicating that the resident was looking for their tablet device which was charging in the staff office at the time.
- Shortly after another resident approach the inspector with a staff member present. The resident pointed towards the staff office door (which was closed

and locked at the time) and walked in the direction of this door with the staff member following them. This staff member then told the resident that they could not enter the office with the resident then following the staff member to the larger sitting room.
- The atmosphere during this period of observations was quiet and calm.

Near the end of the inspection, an inspector visited a separate sensory room to the rear of the centre with a member of management. One resident was this room at the time watching a television. When the inspector left this room, the resident said goodbye when encouraged by the staff member. Soon after this, a feedback meeting for the inspection was held with management of the centre. While this was happening two of the resident's left the centre via the centre vehicle to go horse riding. After the feedback meeting had concluded, inspectors left the centre and said goodbye to residents present in communal areas at the time. Such residents did not interact with inspector but one of the resident did interact with one member of management present. The atmosphere as inspector's left the centre was again quiet and calm

In summary, while some residents did not generally interact with inspectors, it was seen that some residents left the centre during the course of the day. For residents that remained in the centre, it was seen that attempts were made to engage residents through the use of a sensory room or with games. Two mealtimes were observed during this inspection with such observations reflected elsewhere in this report.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

While there was evidence that the provider had implemented actions from the previous inspection and there was improvement in some areas, improvement continued to be required in some areas. This included the notification of incidents from the centre.

This centre is run by St Joseph's Foundation. Due to concerns in relation to overall compliance levels from inspections of St Joseph's Foundation's designated centres and other regulatory engagement throughout 2024, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's designated centres. All inspections conducted for the duration of this programme will be unannounced and will have a focus on specific regulations. These regulations are Regulation 5 Individualised assessment and personal plan, Regulation 7 Positive behavioural support, Regulation 8 Protection, Regulation 9 Residents' rights, Regulation 10 Communication, Regulation 16 Training and staff development,

Regulation 23 Governance and management, Regulation 31 Notification of incidents, and Regulation 34 Complaints procedure. These regulations were reviewed on this inspection and this inspection report will outline the findings under each regulation. Due to observations during this inspection, Regulation 18 Food and nutrition was also reviewed.

Registered until December 2026, this centre had been inspected in January 2024, April 2024 and October 2024. Those three inspections along notifications and information of concern received by the Chief Inspector throughout 2024, raised concerns in areas such as practices in the centre, support to residents and safeguarding amongst others. The nature of such concerns prompted additional regulatory engagement with the provider for this centre throughout 2024. Such regulatory engagement included assessing the fitness of the provider in April 2024, seeking specific provider assurances in September 2024 and November 2024 and holding a cautionary meeting with the provider in November 2024. Given the areas of concerns identified during 2024, the current inspection was conducted to assess progress since then in line with the targeted inspection programme.

Overall, this inspection found that efforts were being made by local management of the centre, who had been recently appointed, to address issues and that the provider had implemented actions from the October 2024 inspection. As part of this, the provision of staff supervision had improved. However, some notifications received in advance of this inspection and the inspection findings indicated that further improvement continued to be needed. Such matters will be discussed elsewhere in this report. It was also highlighted that regulatory actions remained in areas that had been highlighted during previous inspection. For example, all three 2024 inspections had found that required notifications were either not being submitted or were not being submitted in a timely manner with some similar findings identified on the current inspection.

Regulation 16: Training and staff development

Discussions with staff and documentation reviewed during the October 2024 inspection confirmed staff working in the centre were not receiving appropriate supervision. In response, the provider had indicated that supervision would be conducted every six to eight weeks and that the person in charge would conduct direct supervision of all staff before delegating supervision responsibilities to social care workers and nurses. Since that inspection, the role of person in charge had changed for the centre and upon commencing the position, the current person in charge (during a formal interview in April 2025) also outlined their intention to supervise all staff. Discussions with staff and records reviewed during the inspection, confirmed that staff working in the centre had received recent supervision in the weeks leading up to this inspection. While confirmation was required, and received, that four particular staff had received supervision following the inspection, the

findings related to staff supervision were a notable improvement from the previous inspection.

Judgment: Compliant

Regulation 23: Governance and management

The October 2024 inspection found high levels of regulatory noncompliance which indicated that the management systems in operation for the centre needed improvement to ensure that the services provided in the centre were safe, appropriate to residents' needs, consistent and effectively monitored. Similar findings had also been found during the January 2024 and April 2024 inspections of the centre. In response to the October 2024 inspection, the provider indicated the measures that they would take to improve the management systems for the centre. These included:

- That a new area manager/person participating in management (PPIM) would be put in place to support the centre.
- That staff would have access to various managers and members of the provider's senior management team.
- The provider's designated officer (person who reviews safeguarding concerns) would, amongst other duties, complete safeguarding audits and attend staff meetings.
- The provider had engaged the services of an external consultancy firm to review this centre in its totality through a number of unannounced visits and audits over the forthcoming 12 month period.

On the current inspection, the following was found:

- A new area manager/PPIM for the centre had been appointed in January 2025. This individual was present during the inspection and engaged with inspectors throughout the inspection, proving any information and documents that were requested during and after the inspection. The area manager was a presence in the centre. For example, based on notes reviewed, they had attended the three most recent staff team meetings for the centre.
- Staff members spoken with demonstrated an awareness of members of local and senior management for the centre. Such staff members also indicated that they could contact any of these managers if required.
- The provider's safeguarding officer had attended two staffing team meetings in centre during 2025. Safeguarding was discussed at these two meetings as well as at all other staff team meetings in 2025 based on records reviewed. Other records read by an inspector indicated that the designated officer had conducted a safeguarding audit in March 2025 which focused on areas such as the provider's policy in this area and staff awareness.
- An inspector was informed that an external consultancy firm had been engaged by the provider and that this firm had conducted an unannounced

visit to the centre in January 2025. A report of this visit was provided which indicated that actions from the October 2024 inspection, previous provider assurances submitted to the Chief Inspector, specific regulations and the culture of the centre were considered as part of that visit. That visit indicated that most previously stated actions had been completed but some had not. When queried during this inspection, if the eternal consultancy firm had conducted any further visits or audits for the centre, an inspector was informed that they had not but were expected to complete another unannounced visit for the centre.

Aside from the measures outlined above, other documentation reviewed during this inspection indicated that various audits within the centre by local management in areas such as medicines, finances, staff files, cleaning and personal plans were being conducted. An annual review for the centre for 2024 had also been carried out in March 2025 which assessed the centre against relevant national standards while also providing for feedback from residents and their representatives. The report of this annual review was found to consider various areas relevant to the quality and safety of care and support provided to residents such as activities, medicines and positive behaviour support. Ultimately, such documentation reviewed along with discussions with the PPIM indicated that there were management systems in place for the centre.

However, the statement of the purpose for the centre, which formed the basis of a condition of the centre's registration indicated that the provider was committed to providing high quality safe services that offered residents choice and aimed to promote their independence. The notifications and information of concern received throughout 2024 along the findings of the three 2024 inspections raised concerns around practices in the centre, support to residents and safeguarding amongst others. In the time leading up to the current inspection, some further notable notifications were received from the centre. While it was acknowledged that management of the centre had responded to such concerns, and specific processes had been followed where required, the nature of these notifications raised similar concerns as to 2024. Some of these matters are discussed elsewhere in this report.

It was also noted that both the October 2024 inspection and the January 2025 unannounced visit raised issues around nutrition, fluid balance recording and notifications. Despite this, the current inspection found regulatory actions relating to all three areas. Findings in other areas also raised concerns around how residents were being offered choice and if their independence was being promoted. Such findings indicated that the centre's management systems continued to need improvement to ensure that all relevant issues were identified and addressed in a timely manner and that the services outlined in the centre's statement of purpose were being delivered. The ultimate responsibility for this under the regulations rests with the registered provider, namely St Joseph's Foundation

Judgment: Not compliant

Regulation 31: Notification of incidents

In line with this regulation certain events or occurrences in a designated centre must be notified to the Chief Inspector with specific time frames. Amongst these are any allegations of abuse and any allegations of a misconduct, both of which must be notified within three working days. From documentation reviewed during the inspection, it was identified that two relevant notifications had not been notified within this time frame. These were:

- A safeguarding incident between two residents occurred on 5 January 2025 but was not notified until 14 January 2025. While it acknowledged that adverse weather played a role in the notification being submitted late, communication received about this also indicated that poor communication was a contributory factor.
- An allegation of misconduct was reported at 8am on 30 April 2025 but the Chief Inspector was not notified of this allegation until 10:34pm on 6 May 2025. Excluding an intervening weekend and bank holiday, this meant that there had been over 86 hours between the initial allegation being reported and the Chief Inspector being notified. As such, this allegation had not been notified within three working days.

Other than matters which require notification within three working days, some other occurrences in a centres must also be notified to the Chief Inspector on a quarterly basis. These include the use of any restrictive practice in the centre. While notifications of restrictive practices in use had been received for the centre since the October 2024 inspection, most recently on 30 April 2025, not all restrictive practices had been appropriately notified. For example, the use of a Perspex screen, which amounted to an environmental restriction, had been in use since November 2024 without being notified.

Judgment: Not compliant

Regulation 34: Complaints procedure

According to records reviewed, complaints were indicated as being discussed during residents' meetings that took place on a weekly basis in the centre. For example, some meeting notes made reference to residents being shown a picture of the provider's complaints officer. A picture of this complaints officer along with their contact details was seen to be on display on a poster in the centre's kitchen-dining room. This poster also outlined how if residents wanted to make a complaint, they would be helped by staff, could write their complaint down or speak with the person in charge. The provider used an electronic system for recording any complaints made. An inspector reviewed this system and noted that no complaints had been logged on this since the October 2024 inspection.

Judgment: Compliant

Quality and safety

Improvement was identified during this inspection relating to residents' choice around meals. A compatibility assessment had been completed since the previous inspection. Alleged statements made by staff to a resident were a cause for concern.

The frequency of resident meetings had increased since the previous inspection. This was an improvement with such meetings used to discuss issues like activities and meal plans. However, based on documentation reviewed and observations during this inspection, it was not evident that residents were being offered sufficient choice regarding the meals that they had. Meal choices had been highlighted as an area in need of improvement during the previous inspection in October 2024. The same inspection also raised compatibility concerns in the centre given the volume of safeguarding incidents occurring between residents. Since then a compatibility assessment had been completed and recommendation had been generally implemented. However, safeguarding incidents between residents could still occur. The nature of alleged statements made to one resident by staff raised further safeguarding concerns.

Regulation 10: Communication

Residents living in this centre were supported to develop a communication profile outlining how they communicated. Such profiles had speech and language therapist (SLT) input while also outlining the supports residents needed to communicate and how residents communicated in specific areas such as indicating yes or no. The profiles seen were noted to have been reviewed within the previous 12 months. Aside from these profiles, it was indicated and seen that residents had access to media such as Internet and smart televisions with one resident having a tablet device also.

This resident's communication profile stated that staff were to encourage the resident to use their tablet device to request what they wanted including food choices. However, a separate support plan for use of the tablet stated that they were not to have their tablet device until after they had completed their morning routine (including having their breakfast), and that they did not bring the tablet on activities. This was despite a different support plan for activities stating that the resident brought the device on activities as they used this to communicate.

Staff spoken with noted that the resident would not utilise a communication app on their device but they had now received a second device which was going to be used for communication. This was not being used at the time of the inspection as they

were awaiting SLT review regarding this. Towards the end of the inspection, it was highlighted that that there was an identified restrictive practice in use in the centre whereby the resident was not to be given their tablet device until after 2pm. It was indicated to inspectors that this restriction was implemented as otherwise the resident would not want to go out for activities away from the centre. Ultimately, the use of this restrictive practice, the resident's communication profile and different support plans were not consistent related to the resident's communication's supports.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

During the October 2024 inspection, some regulatory actions were identified relating to aspects of meals and nutritional support. The unannounced visit to the centre in January 2025 found that "significant improvement" was required for food and nutrition. Based on observations during this inspection, such matters continued to be in need of improvement. For example:

- Placemats had been developed outlining the feeding, eating and drinking requirements for residents with these placemats observed to be used at mealtimes during this inspection. Upon review it was noted that one resident's placement stated they required a calm environment free from distractions at mealtimes. This included guidance for staff members not to make loud noises around the resident while they were eating. During breakfast time an inspector observed that the radio was on, that the microwave was being used and that the door between the utility and kitchen-dining room banged on a number of occasions as a staff member prepared the resident's breakfast. The resident could be observed placing their fingers in their ears on occasions during the breakfast time. As such, it was not evident that the meal time environment was consistent with the resident's needs and preferences.
- It was also observed on the day of inspection that residents were not encouraged to participate in cooking or the preparation of meals and drinks in their home. In particular, it was seen that residents were seen being handed their meals by staff members which was not promoting the independence of the residents.
- Staff members had plans to complete the centre's grocery shopping on the morning of the inspection. When asked if residents completed the grocery shopping with staff members, an inspector was informed that they did not and that a staff member was dropped off at the grocery shop while another staff member brought residents for a drive in the centre's vehicle.
- As residents were having their breakfast, staff members were observed preparing potatoes and vegetables for dinner. When asked by the inspector, staff members noted that this was a staffing preference rather than a

resident preference as dinner was provided to residents early in the afternoon and some staff members liked to have this ready in advance.

- At one point a resident was supported by staff members to have a cup of tea with one staff member offering the resident a biscuit to which the resident accepted. However, the staff member then noted that there were no biscuits available to give to the resident.
- One resident had a specific plan for feeding and nutrition completed with dietitian input. This plan provided guidance for staff to encourage the resident to eat specific items including protein milks and protein yogurts. These were not available on the day of the inspection. Staff members completed the grocery shop for the centre on the afternoon of the inspection and these items remained unavailable. When queried, staff members advised that they planned to do more shopping later in the evening in another supermarket to get these items.
- An inspector also reviewed the record of meals and choices provided to the same resident during June 2025 and noted that recommendation made by the dietitian were not documented as being provided to the resident. For example, seeds that were to be included in the resident's breakfast were not documented, while sauces to be used when blending the resident's meals were also not recorded. Although staff spoken with were aware of the requirement for the resident to have these additions to their meals, and some of this was observed being prepared at mealtimes, it was not accurately reflected in the documentation.

Issues relating to residents' choice at mealtimes is addressed under Regulation 9 Residents' rights.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

When reviewing the personal plans for five residents it was noted that a clear assessment process was in place with any assessed needs in areas such as residents' health and activities of daily living, reflected in corresponding support plans. Such plans having been reviewed within the previous 12 months while reviews of residents' personal plans took place on an annual basis based on records reviewed and discussions during the inspection. However, some areas for improvement were observed from the personal plans reviewed. These included:

- Some documentation in residents' personal plans were not consistent with other records. For example, information around a PRN medicine (medicines only taken as the need arises) was stated differently in a resident's personal plan compared to their prescription records.
- Residents had been supported to make goals that they would like to achieve, with easy-to-read information being provided to explain what residents could expect with these goals. However, it was noted that there was some

repetition of residents' goals with the same easy-to-read guidance being provided to a number of residents. For example, when reviewing the personal plans of three residents, it was noted that all three residents had the same goal to visit a specific train station and to go to a local mart. In addition, two residents had a goal to go to the zoo and complete social farming.

- One resident required fluid monitoring in line with their assessed needs and associated support plans. During observations in the centre, the resident was seen to have three drinks in a twenty minute period. Staff members did not use a measuring jug provided to record the fluids given to the resident while preparing these drinks for the resident. It was also noted that only two of these drinks were recorded on the fluid balance recording sheet at the end of the inspection. Issues around the maintenance of fluid balance charts had been raised by the October 2024 inspection and by the January 2025 unannounced visit to the centre.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Some restrictive practise were in use in the centre and documentation provided indicated that such restrictions had been reviewed recently by a multidisciplinary team. One of restrictions in use in the centre was the looking of the staff office door with the documentation reviewed indicating that this was to be locked as certain times only and that residents would be granted access to the office if they requested this. Throughout the inspection the staff office door was seen to be locked aside from when it was being used to enter or exit the staff office. The office door was also briefly opened by a member of management when an inspector was querying the use of this door but was closed shortly after a request by the inspector for privacy reasons.

As mentioned earlier in this report, at one point during the inspection, one resident indicated that they wanted to access the staff office but was told by a staff member that they could not enter. As such the locking of staff office and a resident's request to access this office were not in keeping with relevant documentation in place on the on the day of inspection. Following the inspection it was indicated that a further restrictive practice meeting had taken place with the restrictive practice documentation updated to reflect that the staff office door was to be locked at all times.

Aside from restrictions, given the assessed needs of residents living in the centre, residents had guidance in place to support them to engage in positive behaviour. Such guidance outlined strategies to adopt with residents to support them in this regard. However, when reviewing the personal plans of two residents, it was noted that these residents' positive behaviour support plans had not been reviewed in over 12 months. Other positive behaviour support plans were seen to have been reviewed in recent months and staff members spoken with demonstrated a good

knowledge of such plans. Further records reviewed also indicated that staff had completed relevant training in de-escalation and intervention. It was also indicated to inspectors that all positive behaviour support plans were in the process of being reviewed and a behavioural specialist was involved in this process.

Judgment: Substantially compliant

Regulation 8: Protection

In keeping with this regulation, residents should be protected for all forms of abuse with the provider's statement of purpose also indicating that the provider was committed to providing safe services. The same six residents had been living together in this centre for a numbers of years. Inspections findings from April 2024 and October 2024, coupled with a high volume of safeguarding incidents occurring in the centre involving residents during 2024 raised concerns about compatibility of these residents to live together. Following that inspection the provider's multidisciplinary team completed a compatibility assessment and shared the outcome of this assessment with the Chief Inspector in December 2024. This indicated that the centre was home for six residents "with a variety of complex needs" and that it was "difficult to make a fully accurate assessment of compatibility". The assessment also highlighted that at times during 2024 "safeguarding concerns were elevated due to the complexities highlighted". As a result of number of recommendations were made by the multidisciplinary team. These included:

- That one particular resident would benefit from the availability of year-round psychiatry input.
- That residents would benefit from additional space..
- That a second vehicle for the centre should be available "24/7" to facilitate social outings.
- That ongoing training related to "the complex interplay between intellectual disability, behavioural profile & mental health needs" for staff would be beneficial.

On the current inspection the following was found with regard to the above recommendations:

- At the time of the inspection one particular resident was without psychiatry input having been recently discharged from one psychiatrist. However, it was indicated that this resident had been recently reviewed by their former psychiatrist and was due to be taken on by another psychiatrist. An inspector was informed that all other residents of the centre were in the same situation regarding psychiatrist input.
- An external shed to the rear of the centre had been recently converted into a sensory room which residents could access. While this area was not part of

the footprint of the centre, it was seen by an inspector (with permission of a member of management) with a resident seen to be using it at that time.

- The centre had one vehicle specifically assigned to it and the centre could access a second vehicle from the provider's day services for certain hours during week days and all through weekends. Such transport arrangements were similar to those that were in place at the time of the compatibility assessment. As such the centre did not have access to a second vehicle 24/7 but inspectors were informed that a business had been submitted for this. During the morning of the inspection, at a time when the centre did not have access to the vehicle from day services, a staff member was overheard to suggest to another staff member if they could take a resident for a drive. This was not possible at the time as the one assigned vehicle for the centre was being used for other residents. As such, a drive was not offered to the resident at that time although, given the needs of the resident, it was possible that the resident would have refused this had it been offered.
- Regarding the training related to "the complex interplay between intellectual disability, behavioural profile & mental health needs", it was confirmed following the inspection that staff had completed training on 'Understanding Behaviours of Concern: Level 1." When it was subsequently queried if this delivered training met the recommended training in its totality, it was indicated that met the compatibility assessment's recommendations and was specific to the centre and needs of residents. The post inspection received also confirmed that some new staff working in the centre had not completed the training but that such training would be delivered again, approximately eight weeks after the inspection.

Aside from the recommendations from the compatibility assessment, it was noted that notifications of a safeguarding nature involving interactions between residents had decreased since the October 2024 inspection. However, such incidents could still occur. For example, in March 2025 one resident had been impacted by the vocalisations of another resident while in May 2025 one resident had bitten another resulting in slight redness and bruising. For any safeguarding incident or allegation that had been notified since the October 2024 inspection, records provided indicated that these were screened by the provider's designated officer with safeguarding plans put in place. Such plans outlined measures to prevent incidents between residents reoccurring and included the supervision of residents by staff. During the inspection, appropriate supervision of residents was generally in place with some residents specifically assigned 1:1 staffing. However, on one occasion while an inspector was observing residents in the larger sitting room, a staff member asked the inspector if they were staying in the room as the staff indicated that they needed to leave. The inspector explained that they could not supervise a residents as they were not a staff member. At this time, a second staff member overheard this conversation and came to supervise the residents while the first staff member left the room.

It was also noted that, while staff had completed safeguarding training and did demonstrate an awareness of some of the safeguarding plans in place between specific residents, they did not demonstrate an awareness of all of them specifically safeguarding plans involving certain residents. It was acknowledged though that

there was a high volume of active safeguarding plans at the time of this inspection with documentation reviewed indicating that there were a total of 59 open safeguarding plans, all relating to residents impacting one another. It was also accepted that some of these safeguarding plans related to incidents that occurred before the October 2024 inspection and that there was overlap in some of these safeguarding plans with such plans due to be consolidated. However, the volume of the safeguarding plans indicated that residents had not been protected for all forms of abuse over a period of time with all six residents each involved in multiple safeguarding plans. It was also unclear if some of these safeguarding plans were effective. For example, regarding the resident who had bitten another in May 2025, this was a recurrent incident in the centre and there was 13 open safeguarding plans relating to the former resident impacting the latter.

Aside from matters related to incidents occurring between residents, when reviewing one resident's personal plan, it was noted that reference was made to the resident being "a person with immense anxiety issues". It was also indicated in the resident's personal plan that they could be anxious with general practitioners, medical procedures and hospitals with the resident also prescribed chemical sedation prior to medical appointments. Despite this, a notification was received from the centre in the days leading up this inspection which alleged that "all staff" were mentioning going to the hospital to the resident in a specific context. The same notification also indicated that the word "hospital" caused anxiety and upset for the resident. Once this allegation was raised management of the centre they put in place a safeguarding plan and as part of these sought to supervise certain events in the centre. During the introduction meeting for the inspection, an inspector was informed that when supervising such an event the day before this inspection, it had been reported that one staff member allegedly mentioned hospital to the resident. While both of these allegations were subject to further investigation, the nature of such matters raised concerns given the issues that were evident for this centre throughout 2024 related to safeguarding, supports to residents and practices in the centre.

Beyond this matter, during the inspection, two residents were heard making safeguarding allegations in the presence of an inspector. One of these was also made in the presence of a member of a centre's management and was formally notified following the inspection. This notification indicated that the resident had retracted the allegation. For the other resident, the resident made their allegation when with a staff member. This staff member provided reassurance to the resident. This resident had a specific plan in place related to such allegations and the staff member was aware of this. This plan, which had been reviewed in April 2025, had the input of the provider's designated officer. Given the nature of the allegation made by the resident, this matter was not formally notified as a safeguarding allegation in line with the plan in place.

Judgment: Not compliant

Regulation 9: Residents' rights

Given their particular needs around the self-ripping of clothes, one resident had inventory of belongings in place. However, two inventory of belongings were completed for this resident on 10 June 2025 and 27 May 2025 which these both listed different numbers of items and it was not evident that these had been updated to reflect items that either were purchased or destroyed. It was also noted that these inventories of belonging were not recorded in line with the provider's policy which stated that such inventories should be recorded on a specific form. Issues around the maintenance of such records for the same resident had been raised during the October 2024 inspection also.

Documentation reviewed for three residents on the current inspection indicated that they were consulted and given information through individual resident meetings that took place on a weekly basis. The frequency and occurrence of these meetings was an improvement from the previous inspection. Notes of these meeting reviewed for three residents from April 2025 on indicated that matters such as activities, safeguarding and complaints were recorded as being discussed with residents. These meetings also recorded that meals plans for the weekend were discussed with residents which, upon initial viewing, were positively noted as issues around residents' meal choices and consultation with residents around these had been raised during the October 2024 inspection.

However, when reviewing the resident meeting notes for one resident that was completed on 8 June 2025, it was indicated that the resident wanted chips, pizza, pasta, chicken, sausage, pudding and apples for the week ahead. Despite this, on the day of the inspection (which was on a Friday) it was seen that all residents received fish for their lunch with an inspector informed by a staff member that fish was always served on a Friday. There was no evidence of any alternative meal choice being provided to residents during the lunch observations. While it was noted that all residents ate the meal they were provided by staff, other observations at mealtimes during this inspection and documentation reviewed, did not assure that residents were routinely offered choices as to what they would like to eat, or that choices were communicated to residents effectively.

For example, for breakfast a staff member was observed showing a resident bread and eggs and asked the resident if they would like both items for breakfast. The resident pointed to the bread, not the eggs but the staff member proceeded to make the resident both items. It was then noted by the staff member that the bread had expired and they made the resident some waffles instead. As a result, the resident was not provided with a breakfast in line with the choices they had been given or that they had chosen. On another occasion, a staff member was observed making a resident's breakfast without offering any choice as to what they would like to eat. When asked by the inspector, the staff members reported that the resident would always choose this breakfast.

In terms of relevant documentation, residents also had daily menu logs which were to be used to record what choices of meals residents were offered and what meals they actually had. Inspectors reviewed a sample of these daily menu logs and noted that, while they did record what residents were given, they did not consistently

record what choices of meals residents were offered. For example, for one resident for two recent days before this inspection the resident was not recorded as being offered any choice in their meals.

Aside from choices for meals, from documentation reviewed, it was also noted that some communication and environmental recommendations had been made by an SLT to support the residents living this centre including around their choices. Although these recommendations referred to children, the documentation seen noted that choices should be offered to residents to encourage leisure activities in addition to chores. In keeping with this, a visual schedule was in place in the centre that outlined the residents' plans for the day. This board was observed to have been completed for residents prior to the residents getting up on the morning of the inspection. It also recommended the use of choice boards which were not available on the day of the inspection.

Other documentation reviewed during this inspection included a consent and signature support plan for two residents. For one of these residents, their support plan in this area outlined they had good comprehension of verbal prompts and could mark their signature when necessary. It also clearly outlined that the resident required staff support to verbally explain what they were or were not consenting to while using familiar language. These consent and signature support plans further referenced how the residents could imply consent in line with their communication profiles.

Judgment: Not 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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Blossomville OSV-0001822

Inspection ID: MON-0045916

Date of inspection: 13/06/2025

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The actions identified in the report provided by the external consultancy firm have been completed except: • The recruitment of permanent staff- this is ongoing; permanent HCA transferred to the Centre in May 2025, one social care worker who was working as a HCA until exam results were received have received these results and transferred to the full time social care worker vacancy, one permanent staff Nurse commenced on the 23/06/2025, 5 HCA vacancies remain- recruitment is ongoing and HR dept. have advised there are a number of HCAs currently onboarding. • Ensure all staff have attended Restrictive Practice Training- this training was rolled out to PIC's and senior staff members initially. HCA's have now commenced attending this course- 6 staff member from the Centre attended on 29/07/2025. Remaining staff were scheduled to have completed this training by the end of September 2025 however this date has been rescheduled to 17/11/2025. The external consultancy firm completed a second unannounced visit on 19/06/2025 and completed the centre' six monthly audit on this date. The report has been received an action plan is in place. There are concerns around practices in the centre and management are responding to such concerns by; • Having an increased presence in the Centre • The Person in Charge will have an increased presence on the floor of the centre to allow for supervision of staff to assess and monitor practices of concern, monitor how residents are being offered choice, ensuring independence is being promoted and come in to compliance with Regulation 23: Governance and Management and ensuring the services outlined in the center's Statement of Purpose are being delivered. • A senior staff member is supervising each meal time • A protocol for a resident who requires 1:1 supervision was devised on the 16/07/2025 and is read and signed by the residents allocated staff daily • Each resident was reviewed by an external Dietician on 22/04/2025 and the 29/04/2025, report received on 27/05/2025, recommendations implemented on	

09/06/2025. The grocery list has been updated to include items recommended by Dietician are available to residents. The Person in Charge has spoken with all regular staff regarding recent safeguarding concerns relating to Nutrition.
• Following further discussion with one residents GP on the monitoring and recording of fluid intakes, the GP requested such monitoring to be discontinued. Fluid monitoring records for this resident were discontinued on 23/06/2025.
• The current Registered Person in Charge and PPIM are reviewing all notifiable events and practices regularly to reduce the risk of any further notifications being submitted outside of the required timeframe. Any three day notifications will be submitted within three working days by 5:30pm.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All staff are aware that safeguarding incidents must be recorded and reported in a timely manner in line with local and national policy and HIQA regulations. Safeguarding incidents are discussed at each staff handover as a standard agenda item, this was discussed at the most recent team meeting on 21/07/2025.
• A Perspex screen prescribed on the 25/11/2024 as a restrictive practice by the MDT, previous PPIM and previous Person in Charge should have been notified in January 2025 reflecting its use in the fourth quarter of 2024 via an NF39A form. The current registered Person in Charge submitted this to the Chief Inspector via an NF39A form on the HIQA portal retrospectively 25/07/2025.
• Night checks prescribed for one resident on the 06/06/2024 was not notified by the previous registered Persons in Charge for the third and fourth Quarter of 2024 via an NF39A form. The current registered Person in Charge submitted two NF39A forms (reflecting its use in Quarter three and Quarter four of 2024) to the Chief Inspector on the HIQA portal retrospectively on 25/07/2025.
• The current Registered Person in Charge and PPIM are reviewing all notifiable events and practices regularly to reduce the risk of any further notifications being submitted outside of the required timeframe. Any three day notifications will be submitted within three working days by 5:30pm.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• A new referral was submitted to the resident's Speech and Language therapist to review the resident's communication profile in light of the inconsistencies noted, on

review of the current communication profile and the prescribed restrictive practice for the residents access to their iPad. The Speech and Language Manager reviewed the residents profile with the resident and staff members and an updated profile was forwarded on the 25/07/2025. Staff have been informed and it was discussed at a team meeting on 30/07/2025. There are no further inconsistencies in the documentation for the resident.
• A restrictive practice review meeting was held on the 29/07/2025 to reflect changes in the updated communication profile

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The Person in Charge wishes to confirm the use of the radio in the kitchen area was due to a recommendation made by an external auditor in an attempt to create an ambient environment during meal times. Following discussion and review with the services Speech and Language Therapy Manager, the use of a radio during mealtimes is no longer recommended. Providing a calm environment at mealtimes remains a priority for all residents residing in this centre. The Speech and Language Therapy Manager also reviewed and updated all residents' placemats including the placemat in question on 25/07/2025. All staff have been informed of such and are aware of the changes made and will ensure recommendations are implemented at each mealtime. The PIC has spoken with all senior staff members to ensure they are monitoring the implementation of recommendations on a daily basis and this has also been discussed at a staff meeting on 30/07/2025.
• Regarding the preparation of meals and drinks; all residents are now offered and encouraged to participate in meal preparation daily and grocery shopping. Staff encourage residents to set the table, become more involved in the preparation of meals and bring their delph to the basin/dishwasher. In addition, all resident's activity charts have been updated and now include activities relating to meal preparation, grocery shopping and household chores.
• We wish to acknowledge it is not appropriate for staff to prepare vegetables for dinner when residents are having their breakfast. The Person in Charge has spoken with all staff regarding this at team meetings on 21/07/2025 and 30/07/2025. This is also in line with updated recommendations received from the Speech and Language Therapy Manager where it is documented on placemats to "provide a calm environment free from distractions".
• The Person in Charge wishes to confirm to the Chief Inspector that the frequency of grocery shopping has been reviewed. Grocery shopping is now completed on Mondays and Fridays and if items are required outside of these days they will be purchased. The grocery shopping list has been updated and now includes all items recommended by the Dietician in recent reviews for example; protein milk and protein yoghurts and items residents frequently request for example biscuits (which were not available on the day of inspection).

• The Person in Charge wishes to confirm that the documentation for the recording of meals and food choices has been updated on the 01/07/2025 to include sections for seeds and sauces. This is completed daily by staff and checked by the senior staff member on duty at the end of each shift. Each staff member is now aware of recommendations provided by the Dietician for each resident. Further to this an additional support plan explaining the recommendations has been devised for each resident and is in situ since 22/07/2025.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The Person in Charge wishes to confirm they are in the process of completing a detailed review of each residents personal plan. The personal plans for all residents will be fully reviewed and updated to ensure that they are consistent with other records by the 14/08/2025.
• Regarding a residents PRN Kardex which was inconsistent with their personal plan; this was rewritten on 19/07/2025 and has been submitted to the residents GP.
• The Person in Charge wishes to confirm that all easy read documents pertaining to goals have been updated on 18/07/2025 to ensure that they are more individualized to each resident. The Person in Charge acknowledges similarities with the goals of three residents, however this is due to these three residents having similar interests for example- trains and farming.
• As outlined under Regulation 23 above, the Person in Charge wishes to confirm that following further discussion with one residents GP on the monitoring and recording of fluid intakes, the GP requested such monitoring to be discontinued. Fluid monitoring records for this resident were discontinued on 23/06/2025 with staff being informed of same.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The Person in Charge wishes to confirm that a restrictive practice meeting was held on the 18/06/2025 to further discuss the office door being closed at all times. The restrictive practice now states that the office is closed at all times with the keypad activated for the protection of data and preventing unauthorised access. If residents request access to the

office this should be granted with the supervision of a staff member, provided a medication round, staff supervision and/ or confidential meetings either face to face or via telephone are not taking place. The Person in Charge has made all staff aware of the updated restrictive practice during handovers and again at a team meeting on the 21/07/2025.
• The Person in Charge wishes to confirm that the two Positive Behavioral Support Plans that had not been reviewed in over 12 months were updated on the 18/06/2025, thus all Positive Behaviour Support Plans are now all in date in the Centre and staff are aware of same. In additional to this, the behavioural specialist working with the centre is currently in the process of completing functional assessments and is visiting the centre regularly to meet with residents and staff.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Regarding Psychiatry input for residents residing in the centre; all residents were reviewed by their previous Consultant Psychiatrist on 25/03/2025 and we continue to await feedback on the appointment of a new Psychiatrist. In the interim residents have access to their GP and acute services if/as required. An outpatient appointment with a different Psychiatrist was received for one resident for the 05/08/2025 following a recent discharge from an acute admission however the resident was unable to attend this appointment. This appointment is being rescheduled, we are awaiting a new date.
• The Provider wishes to confirm that a business case has been submitted for a second vehicle, however at the time of writing this response an update on same is not available. The Person in Charge wishes to confirm the centre has access to a second vehicle from 1pm to 8pm Monday to Friday and from Friday afternoon at 1pm through to Monday morning at 8am. The centre also has access to a taxi service should it be needed. The availability of this taxi service has been reiterated to staff at a team meeting on the 21/07/2025 and 30/07/2025.
• The Person in Charge wishes to confirm that additional training on "Understanding behaviours of concern: Level 1" has been scheduled for 02/09/2025 and the 04/09/2025 and will be delivered to staff by the Provider's Psychology Department.
• The Person in Charge wishes to confirm that all staff have been reminded of the importance of supervising residents and this is being monitored daily by senior staff members on duty.
• The Person in Charge wishes to confirm all safeguarding plans were reviewed in detail by the Person in Charge and the Providers Designated Officer on 27/06/2025 and 29/07/2025. This thorough review resulted in a significant reduction of open safeguarding plans in the centre due to the consolidation of many of these plans; for example, 13 open safeguarding plans were consolidated to 1. The Person in Charge wishes to advise that the number of open safeguarding plans in the centre has reduced from 59 to 11. The current open safeguarding plans were discussed in detail with staff at a team meeting on 30/07/2025.
• To ensure the effectiveness of safeguarding plans in the centre, the Designated Officer

has agreed to increase the frequency of six-monthly reviews to three monthly and further reviews will be completed if required. The next review has been scheduled for 01/09/2025.
• Regarding the notification submitted to the Chief Inspector pertaining to the use of the word "hospital", the Person in Charge can confirm the Provider reviewed the matter internally and actions are in situ including; education with staff and increased supervision. The education piece was completed with each staff member individually, with the final staff member completing same on 28/07/2025.
• The Chief Executive Officer has requested the MDT to complete a review of the compatibility assessment for residents which was completed on 13/11/2024. The Chief Executive Officer has requested this review to be completed by 03/10/2025.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Person in Charge can confirm that the inventory of belongings for the resident in question has since been updated on 17/07/2025 and is being completed as required to reflect items that are purchased and destroyed. Such items are now recorded on the correct template in line with the Providers Policy. To ensure effective monitoring of residents inventories the Person in Charge will conduct random checks of this log.
• The Person in Charge wishes to confirm they have completed a thorough review of meal planning in the centre. As of 18/07/2025, residents are now offered choices for meals through the use of choice boards (using visuals) each day. The choices offered and what meal each resident chose is recorded in each resident's "Food and Nutrition log". All staff members are aware of this new approach to meal planning and choice for residents and same was discussed at team meetings on 21/07/2025 and 30/07/2025. To ensure staff compliance with the log, the shift lead will review these logs daily and the Person in Charge will complete random checks of these logs.
• The guidance document devised by the centres Speech and Language Therapist which included a typo error- referring to "children" was rectified on 19/06/2025.
• The Person in Charge wishes to confirm that choice boards are now in use in the centre for activities as of 21/07/2025. The residents assigned staff completes the choice board for activities with each resident every morning and completes the visual schedule based on the residents choosing. The Person in Charge has updated the recording template for activities on 30/07/2025 which now reflects all activities offered, participated in and/ or refused each day. To ensure staff compliance with the activity chart the shift lead will check for completeness at the end of each shift. In addition, the Person in Charge will complete random checks of these logs.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	29/07/2025
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/07/2025
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Not Compliant	Orange	30/07/2025

Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Not Compliant	Orange	01/07/2025
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.	Not Compliant	Orange	17/11/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	21/07/2025
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse	Not Compliant	Orange	30/07/2025

	incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	25/07/2025
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in	Substantially Compliant	Yellow	18/07/2025

	accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	14/08/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	19/07/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	21/07/2025

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	03/10/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/07/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	18/07/2025