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:	Camphill Community Grangebeg
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	15 October 2025
Centre ID:	OSV-0003621
Fieldwork ID:	MON-0048151

About the designated centre

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

Grangebeg Camphill Community is a residential service for up to 12 men and women over the age of 18 with intellectual disabilities. According to the centre's statement of purpose people live, learn and work with others in healthy social relationships based on mutual care respect and responsibility. The designated centre consists of two, two-storey premises on a campus. Each of the houses have a number of private and communal spaces. Residents have access to gardens and plenty of outdoor spaces and the centre is based on a farm, which is situated in a rural part of Co. Kildare. Support is provided 24 hours a day, seven days a week by a team comprised of a person in charge, social care workers, social care assistants, and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 October 2025	07:50hrs to 16:50hrs	Erin Clarke	Lead
Wednesday 15 October 2025	07:50hrs to 16:50hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This unannounced, risk-based inspection was carried out over one day by two inspectors as a follow-up to an inspection completed in June 2025. Following that inspection which found significant levels of non-compliance with regulation, a Notice of Proposed Decision (NOPD) to cancel the registration of the designated centre had been issued to the provider. The purpose of this inspection was to evaluate the provider's response to the significant and ongoing concerns previously identified, and to determine their capacity to achieve compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and to sustain any improvements made.

While inspectors found improvements in local governance and the management of maintenance and premises issues, staffing supports within the centre required improvements. It remained the case, as identified during the previous inspection, that one house within the centre continued to rely heavily on agency staff. Compatibility between residents in this house in particular and the impact of behaviours of concern also continued to affect the dynamics within this larger group living environment.

The centre is located in a rural area of Co. Kildare and shares a site with a day service. It consists of two large two-storey buildings and forms part of a wider campus that includes a commercial-style kitchen, offices, a working farm with a variety of animals, a maintenance workshop, machinery storage shed, polytunnel, and extensive gardens.

Inspectors met with residents living in one house early in the morning as they were having breakfast and preparing for the day. The house was a large two-storey building accommodating six residents. While the premises contained a substantial number of rooms, including bedrooms for volunteers, bathrooms, and other spaces, in excess of twenty rooms in total, there remained limited communal space available to promote residents' comfort, privacy, and enjoyment of their living environment. Due to the assessed needs of residents living in this house, five staff were rostered on duty each day. Combined with six residents, this resulted in a large number of people sharing a limited amount of communal space. Similar to the previous inspection, when inspectors entered the house they observed residents becoming upset with one another, entering personal space, and displaying behaviours that were intimidating or threatening to others.

One inspector spent time at the kitchen table with one resident who was having breakfast. The resident told the inspector that they "did not like the noisy house but they had new paths but still too many people". A second resident was observed entering the kitchen and attempting to engage with the first resident who requested to be left alone. The second resident continued to reach out and try to grab the first resident's hand until they became unhappy. They told the inspector that this happened in the noisy house a lot and they did not like it. Residents over the course

of the morning spoke to inspectors about things they liked to do but had not done in a few months, these included going fishing or going to the golf course.

Downstairs this house contained a number of bedrooms, a smaller sitting room, and a kitchenette. During the last inspection, this area had been used to store old furniture and equipment awaiting removal. On this occasion, it had been cleaned and reorganised. Staff reported that one resident preferred the quietness of this space, though it remained under utilised overall.

Inspectors found that managing behaviours within one house remained challenging due to the limited communal space available. The mix of residents with complex support needs and the restricted shared areas made it difficult to maintain a calm and settled environment. Staff had to continuously manage the physical environment, adjust room use, support residents to move safely between spaces, and provide close supervision to prevent conflict or distress.

Inspectors met with one resident in the second house who was preparing tea before leaving for paid employment. The resident told inspectors that since the previous inspection, the new management team had made a positive difference for them in the centre. The resident said it was reassuring to have a senior person available to raise concerns with and that improvements had been made both within and outside the centre. These included the repainting and sealing of bathrooms, the painting of internal walls, and an increase in staffing levels. New furniture was required in both houses but in one house in particular and this was reported to have been ordered.

In one house within the centre, the daily staff allocation had increased from three to four to reflect the changing and emerging needs of residents. Although the house was registered for six residents, it was accommodating five at the time of inspection. Management outlined that one resident had begun to require increased one-to-one support from core staff, including when attending day services off-site. It was reported that this consistency in support had contributed to a reduction in incidents occurring in the day service. However while two new staff had commenced in the centre with two other staff were going through onboarding, the centre still relied on agency staff.

In the second house, which had a similar layout and size to the first, inspectors were informed that, due to safeguarding concerns, the provider was developing a plan to create an individual, single-occupancy living space for one resident on the lower level of the house, subject to registration. Additional arrangements in the interim required consideration to ensure that the safeguarding concerns were consistently managed and the person in charge and staff team outlined what was currently under review. This included giving one resident advance notice of another resident coming to spend time in the communal living room and the provision of soft items for one resident who liked to throw items.

Residents in this house spoke to inspectors about the upcoming presidential election and spoke of how the staff had supported them to understand how voting worked. One resident was observed to spend the day either resting on the sofa in the living room or asleep in one of the armchairs, they did not leave the house. Staff report

that despite offering choice the resident would often spend the day lying or sitting on the sofa in the living room and that this was something they needed to review.

Overall, while improvements had been made in relation to the premises and risk management in the centre, it remained the case that improvements were required to ensure that the premises fully met residents' needs. In addition, action was required to ensure that residents impacted by peer to peer safeguarding concerns were supported and protected. The provider had employed a number of staff and efforts had been made to improve continuity of care and support; however, further improvements were required in particular in one house.

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

Capacity and capability

Although the inspectors noted a number of improvements in relation to the governance and management systems within the designated centre such as a more stable management team, clear reporting structures and implementation of robust oversight mechanisms. The provider required further time for these systems to embed and demonstrate sustained improvement. In addition, staffing vacancies were continuing to impact continuity of care in some parts of the designated centre.

Since the previous inspection, inspectors noted some improvements in the management structure. A new person in charge, area service manager, team leader, and house coordinator had been appointed to positions that had previously been vacant, subject to high turnover, or held on an interim basis. This restructuring had strengthened local leadership and improved day-to-day management presence within the centre. However, inspectors noted that staff had very recently been appointed into these positions and were still completing their own induction and probation processes.

Regulation 14: Persons in charge

Since February 2024, the centre had undergone significant management turnover, with five persons in charge and four persons participating in management as identified on the previous inspection in June 2025. The person in charge role had often been held on an interim basis by senior managers, some of whom were not based full-time in the centre.

The new person in charge was found to have the appropriate experience and qualifications to fulfil the role. They had previously worked within the provider’s

organisation in another of their designated centres and were familiar with the procedures, governance systems, and daily operations of the centre. Inspectors found that they had taken action on findings from previous inspections within their remit and were well known to residents, demonstrating a consistent presence within the centre.

Judgment: Compliant

Regulation 15: Staffing

In line with the findings from the previous inspection the centre's staffing arrangements were operating at a level below that defined in the centre statement of purpose. This indicated that staffing was not in line with assessed needs of residents.

Inspectors were informed that the new management team had recently completed a review of the whole-time equivalent (WTE) staffing for the centre. This review identified discrepancies between the WTE figures recorded in the centre's statement of purpose and the actual staffing resources in place, with the WTE figure in the statement of purpose having been under-reported. As a result, the stated WTE was corrected from 19.5 to 23.5 to more accurately reflect the staffing complement required to operate the service. Management reported that 3.5 of these vacant posts had arisen following an increase in the staffing allocation, introduced to provide enhanced support to residents during both day and night shifts in line with their assessed needs.

As the designated centre was operating with a number of staff vacancies, and these shifts were being covered by agency personnel. In one house inspectors found that the roster consistently noted a minimum of 28 shifts a week requiring cover by agency staff (rosters were reviewed from 25 August 2025 up to the date of inspection). These shifts were filled with between 11 and 15 different staff a week. In the second house five consistent agency staff were utilised to fill fewer vacant shifts a week, up to a maximum of 15. This was a reflection of the pattern of overall staffing support with one house having a more stable staff team and the other heavily reliant of agency staffing.

Judgment: Not compliant

Regulation 23: Governance and management

A new person in charge commenced in the role on 5 August 2025, while the new area services manager took up their post on 18 August 2025. The area services manager also held the position of person participating in management (PPIM) and

had senior decision-making responsibility for the centre. This instability had to date impacted the provider's ability to maintain oversight and sustain improvements. Inspectors found that the current increased management presence had provided greater stability and support to the service at the time of inspection.

Further improvement was required at the provider level to demonstrate effective governance and oversight. Inspectors noted that the Board of Management had met only once since the previous inspection, despite the centre having received a notice of proposed decision to cancel its registration. This limited level of oversight did not provide sufficient assurance that governance arrangements were robust or responsive to identified regulatory risks in a sustained manner despite improvement at a local level.

During this inspection, inspectors found new systems in place to monitor, review, and oversee corrective actions and improvement plans. On commencement in post, the area services manager had completed a baseline audit of the centre, which complemented the provider's six-monthly unannounced audit. These actions reflected a more structured approach to governance and oversight; however, further time was needed to determine if these changes would result in lasting improvement.

Inspectors found evidence that the area service manager had undertaken an internal audit of a resident's personal plan on 17 September 2025. The audit demonstrated effective oversight and identified several documentation gaps requiring follow-up. These included inaccuracies in the assessment of need, outdated health and behaviour support plans, restrictive practice records awaiting review, and missing or misfiled care plans. The audit also noted incomplete risk assessments and unconfirmed healthcare referrals to health and social care professionals. While the audit reflected good governance monitoring, further action was required to ensure that these identified gaps were addressed and closed within agreed timeframes.

For example, new restrictive practices were identified during the review of practices in the centre. For example, the removal of personal items from a resident's bedroom had been previously implemented as a safety measure; however, it was unclear how long this restriction had been in place. The measure had not been subject to the organisation's restrictive practice review process or oversight. This finding reflected similar concerns identified during the previous inspection, where there was an absence of documented decision-making within the centre. The restrictive practices, along with other measures such as the introduction of additional staffing supports, were subsequently actioned and placed under review.

The provider had developed a quality improvement plan which the person in charge and area service manager described as a 'roadmap'. This plan combined actions related to governance, risk management, safeguarding and staffing. Some of the overdue and outstanding actions related to the premises, staffing and safeguarding. As previously mentioned, not all of the actions (submitted as part of the providers representation) had yet been completed and while progress had been made, these

areas of premises, staffing, risk, safeguarding and resident compatibility, all needed to be brought to a successful conclusion.

Judgment: Substantially compliant

Quality and safety

Inspectors found that while some improvements had been made since the last inspection, the longstanding issues relating to the suitability of premises remained. In addition, resident compatibility and safeguarding of residents remained an outstanding concern.

In line with the findings of previous inspections, it was identified that the provider had not yet effectively addressed premises issues in this designated centre. This was impacting on the lived experience for some residents. For example, it remained the case that in one home there remained insufficient communal space.

There were ongoing compatibility issues between residents in both houses, with incidents of behaviours of concern continuing to impact the safety and wellbeing of others. The provider had introduced a new compatibility tool to assess and monitor behaviour-related risks and compatibility between residents. This tool provided a structured framework for identifying triggers, assessing the likelihood of behaviours occurring, and evaluating their potential impact on others. While its development represented a positive step towards improved oversight and proactive risk management, the assessment had not been fully finalised with recommended actions.

As a result, a final decision regarding the environmental suitability of the living arrangements for all residents had not yet been determined or implemented.

Regulation 17: Premises

Inspectors observed that a number of premises-related works had been completed since the previous inspection. The inspectors found that work identified as urgently needed at the last inspection had been for the most part completed internally, including fitting of a water softener system and repainting and refurbishing of bathrooms.

Externally the replacement of two wooden footbridges and the clearing of pathways and debris around the site had occurred. Further improvement works were underway, including power washing, the upgrading of certain windows, and landscaping of external areas. One house had recently been repainted internally, with plans in place to repaint the second house in the coming weeks. External

upkeep of both buildings was scheduled, having not been carried out for several years.

The current layout and use of space in the centre remained not fully aligned with residents' comfort, privacy, or sensory needs. In one house this was reported to be under review and some plans for changes to the internal layout were available for inspectors to review however, no final decisions on progression of these plans had yet been made. Furniture in one house was observed to be in poor condition, although inspectors acknowledge that new furniture was to be provided it was not in place on the day of inspection.

In the other house while inspectors found that further communal areas had been developed and made more homely due to the limitations in staffing these areas could not be fully utilised by residents. Inspectors were informed that one resident enjoyed using the sensory room located in the adjoining day service. Management and staff reported that they were exploring the possibility of converting a very small room in the hallway, previously used for storing cleaning equipment, into a sensory space. This space could be easily monitored by staff as they passed in the hallway on the first floor. However, given the availability of larger rooms within the centre, including two offices and five non-registered bedrooms, it was unclear whether sufficient consideration had been given to how the overall living environment could be better utilised to meet residents' assessed needs rather than the predominant location of staff.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The previous inspection found that the provider's systems for oversight and monitoring of risks had not been effective. However, this inspection found that a number of improvements had been made in relation to risk management and more were planned.

A general safety audit was commissioned by the provider and undertaken by an external company to assess compliance with health and safety legislation and internal protocols. The scope of this audit included both the designated centre and the wider site, including the working farm and associated facilities.

Inspectors reviewed the operation risk register and found that there were recorded risks relating to safeguarding, staffing, the premises not meeting residents' needs and risks relating to the grounds and farm. Inspectors found that the operational risk register was now more reflective of presenting risks and control measures. A number of works, as already stated, had been completed to reduce risks relating to the grounds and pathways including the access bridges to the houses since the last inspection however some work remained outstanding at the time of inspection.

Inspectors reviewed a sample of risk assessments for six residents. These documents had been recently reviewed and were found to be in the main reflective of the presenting risks and the control measures in place. For some residents, a number of additional control measures had been implemented and these were proving effective. For example, one resident who was at risk of financial loss was found not to have had any financial reconciliations completed in the preceding year. The person in charge had begun oversight and reviews in line with stated control measures. Additional controls included an review of the resident's asset list, staff training and enhanced person in charge spot checks.

For other residents however, the implemented or stated control measures were not seen to be effective. One resident refused to evacuate during fire drills and the provider could not therefore determine that their fire safety procedures were effective. This risk while assessed as sitting at the highest impact rating remained at this rating despite the implementation of current controls indicating that this required review.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors reviewed compatibility assessments which showed that several residents presented with behaviours of concern that required consistent monitoring and environmental management to maintain safety and reduce distress among peers.

One resident was assessed as displaying physically and verbally aggressive behaviour towards staff and peers, including hitting, pulling hair, throwing objects, and using loud or threatening language. The assessment recorded that such behaviour could cause anxiety, fear, or emotional distress for other residents who witnessed these incidents. To manage these risks, staff were required to implement 1:1 supervision, remove potential triggers from the environment, and redirect the resident when signs of escalation were observed.

Another example documented that a resident occasionally exposed themselves or engaged in smearing behaviour within shared spaces. This behaviour was identified as having a potential psychological and emotional impact on others. Control measures included ensuring that the resident received individual support, and staff redirected other residents access to communal areas when necessary for other residents.

It was further outlined that residents who became verbally aggressive or displayed high vocalisations could trigger anxiety or withdrawal in their peers. Staff were guided to monitor early signs of agitation, implement de-escalation techniques, and support residents to remove themselves from uncomfortable situations. Documentation showed that some residents had developed coping mechanisms, such as notifying staff or moving to quieter spaces when incidents occurred.

While the compatibility assessments outlined how residents' behaviours affected others and set out the actions required by staff to manage these interactions, the outcomes of these assessments had not been concluded at the time of inspection. As a result, decisions on the long-term suitability of the shared living arrangements for all residents had yet to be finalised.

Inspectors again witnessed interactions between peers that were reflective of safeguarding concerns and poor compatibility during this inspection. These incidents had become normalised in one house as 'usual interaction' and were not consistently reported which made trending of incidents difficult. The area service manager further told inspectors that as a number of systems were paper based that added to the challenge of trending and review. The inspectors found that the local management team had completed compatibility assessments with a particular focus initially on one of the two houses that comprise this designated centre. The management team told inspectors that assessing compatibility was a priority for them when reviewing safeguarding needs in the centre.

In one house the safeguarding concerns arising from peer-to-peer compatibility were proposed to be managed with environmental changes and ensuring staff support was present when two residents were in the same location at one time. Incidents were however, still occurring but there was no review mechanism in place. Therefore it was unclear if environmental changes and staff support were or would prove effective.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Community Grangebeg OSV-0003621

Inspection ID: MON-0048151

Date of inspection: 15/10/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Employees refer a friend incentive in place in the service. • One SCW commenced as planned on the 17-11-2025. • The service has employed three different recruitment agencies to support the recruitment process. • The social media expert attended the community on the 8-12-2025 to complete the CMSNs' social media recruitment videos and the staff social media recruitment videos. • The social media expert placed paid adverts in a local community paper on 28-11-2025, which went to print on 02-12-2025. This included advertising via their digital platforms. • One Social Care Worker and one social care assistant are currently onboarding. • Reviewing CVs on the recruitment platforms takes place on an ongoing basis. • Several applicants have been rejected at application stage due to lack of required qualifications and/or unsuitability for the role. The service is committed to hiring a quality staff team who will ensure continued quality care for the CMSNs. • Interviews take place as per shortlisting of candidates.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Board Meetings: A board meeting was held on the 29-09-2025 and attended by the PIC and ASM. A further board meeting was held on the 16-12-2025. A schedule of board meetings and subcommittee meetings has been provided for 2026, to include NRG committee meetings	

and fundraising committee meetings (Feb, March, June, September and November 2026), ESAM meetings, Quality Risk and compliance meetings, Strategic committee meetings (Feb, March, June, September, and December 2026), A & F committee meetings and CCOI full board meetings (Feb, March, June, September, October and December 2026)

• QIP actions:
A QIP was implemented in August 2025 to provide oversight and monitoring of identified actions to ensure an approach to continuous quality improvement in the center. The QIP tool is a working document with new actions being added on a frequent basis. The QIP data since August 2025 is as follows; 141 actions added since inception, 96 actions completed, 37 in progress, and 8 not started. Of the not started actions, none are outside of their planned timeframe for completion.

• Actions pertaining to the assessments for one resident:

11/14 actions have been completed since identification. These include:
1. Updated epilepsy management plans
2. Reviewed goals
3. Successful completion of optical surgery
4. Review of restrictive practices
5. Updated healthcare assessments
6. Consultation with the CMSN regarding their wishes in relation to exploring a mental health diagnosis
7. Risk assessments reviewed and updated where required
8. Improvements in visual schedules.

• The Team lead has consulted with the local PHN to discuss referrals for allied health and social care professionals for the CMSN who directed the Team Lead to local community-based professionals for OT and Physiotherapy. Following conversation with the community-based specialists and barriers noted to referral, the Team Lead reverted to the PHN again who agreed to advocate on CMSN's behalf in relation to OT and physiotherapy referrals. Challenges remained regarding SLT referrals. A second appointment was undertaken with the GP and attended by the team lead and CSO for medical on 05-12-2025. The GP has since submitted the referrals for OT, physiotherapy, and SLT.

Previous compliance plan actions:
• All staff due supervision received same in quarter four.
• A transition planning tool has been developed by the Compliance Team which coincides with CCOI ATD policy was received by the Community on 01.12.2025.
• All Health and safety audit actions noted in the previous compliance plan have been completed as of 27-11-2025.
• The feedback questionnaire was circulated to house-coordinators for review with CMSN's on 02-12-2026. This feedback will be included in the Annual Review of Service Quality.
• Recruitment campaign: One Social Care Worker and one social care assistant are currently onboarding. One Social care worker commenced on 17-11-2025.
• The ASM and PIC liaised with the social media expert who has purchased ads in the local paper, with associated social media platforms on 28-11-2025. These ads went out

to print on 02-12-2025, with the digital impressions following a few days later.
• The social media expert completed a recruitment video with consenting CMSNs and staff on the 8-12-2025.
• Staff SVP training: one employee who was outside their timeframe for refresher training completed same as per scheduled date on 6-11-2025.
• As an additional enhancement to increasing safeguarding awareness in the center, a bespoke, center specific safeguarding training was undertaken with one team with the national safeguarding lead and the CSO for behavior on 10-12-2025

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Upgrading of the external evacuation stairwell was completed on the 06-12-2025.
• A chemical spray was completed as per the scheduled date of 28th October 2025 on the external aspect of the properties under the footbridges. This spray requires 5-6 weeks before any re-application can be provided. Power washing has not been recommended on the external aspects of the homes, as this would negatively impact the existing paintwork.
• The underside of the footbridge was power washed as per scheduled date of 26-11-2025.
• Internal painting was completed on 07-11-2025
• Furniture has been ordered for the upstairs sitting room, upstairs kitchen, downstairs sitting room, proposed sensory room, proposed additional sitting room, and proposed relaxation space. This includes 4 new kitchen tables and chair sets, 5 new 2-seater sofas, 6 new armchairs, 2 bean bags, and a bathroom unit. Purchasing these pieces seeks to address the current furniture in need of replacement and facilitate the re-purposing of various rooms to mitigate protection risks. Deliveries have commenced with items such as armchairs and bean bags having been delivered since the inspection date.
• The kitchen table in the second house was sanded and sealed as per planned date of 10-11-2025
• The upgrading of windows is planned for completion by 30-06-2026 to ensure the risk of disruption to the residents is minimized.
• Landscaping has been completed in line with the planned schedule in relation to trimming back of hedgerows, removal of the willow tree, clearing of the mound near the houses, fencing off of heights, banking cut back, old rubbish cleared away, pathways sprayed with weedkiller and upgrades to manhole covers.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Fire evacuation risk • A repeat fire drill was scheduled and completed on the day of inspection to assess the needs for one CMSN. • The PIC completed a review of the fire drill report to ascertain the needs identified. This review was completed by 05-11-2025. • The CSO and ASM met on 18-11-2025 and agreed a skills teaching process to support the CMSN to learn and develop evacuation skills. The draft skills teaching procedure was completed by the CSO and shared with the management team on the 27-11-2025 for review. The PIC and ASM reviewed the procedure on the 28-11-2025. The procedure was discussed with the house coordinators on the 01-02-2025, prior to circulation to the team for implementation. For the purpose of ensuring consistency of implementation, it has been agreed to commence the skills teaching after Christmas, given home visits over Christmas and the recent temporary evacuation of the center to facilitate planned works. The skills teaching will commence on the 05-01-2026. This seeks to ensure lifelong learning for the CMSN and as a result this process will likely take significant time to reach a successful conclusion. • The fire evacuation risk assessment was reviewed on the 27-11-2025 following receipt of the skills teaching procedure to include the additional controls for implementation. • The CPI instructor has discussed the risk with CPI and enlisted another CPI instructor for support. Together the two CPI instructors will complete an environmental assessment, with support of the PIC, to consider whether a suitable, minimally impactful, maneuver could be considered as effective for use with one CMSN as an interim evacuation measure in event of a real fire situation. This environmental assessment will be undertaken by 30-01-2026. • The Team lead has been in contact with the local fire station who have agreed to attend onsite and review plans. Awaiting a date from them in relation to same. Premises • The external stairwell was upgraded on the 06-12-2025. • Furniture has been ordered for the upstairs sitting room, upstairs kitchen, downstairs sitting room, proposed sensory room, proposed additional sitting room, and proposed relaxation space. This includes 4 new kitchen tables and chair sets, 5 new 2-seater sofas, 6 new armchairs, 2 bean bags, and a bathroom unit. Purchasing these pieces seeks to address the current furniture in need of replacement and facilitate the re-purposing of various rooms to mitigate protection risks. Deliveries have commenced with items such as armchairs and bean bags having been delivered since the inspection date. • The kitchen table in the second house was sanded and sealed as per planned date of 10-11-2025 • The upgrading of windows is planned for completion by 30-06-2026 to ensure the risk of disruption to the residents is mitigated. • Landscaping has been completed in line with the planned schedule in relation to trimming back of hedgerows, removal of the willow tree, clearing of the mound near the houses, fencing off of heights, banking cut back, old rubbish cleared away, pathways sprayed with weedkiller and upgrades to manhole covers. Finances • The PIC is currently designating 1 hour per day specifically for the backlog of financial	

reconciliations. The ASM has arranged for additional support for the PIC to ensure timely completion of the backlog.
• The Provider has instructed the finance team to schedule an audit of the CMSN personal finances for completion by the 30-01-2025 to ensure any issues that may require addressing immediately are highlighted to the PIC

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Compatibility-General actions:
• The incident observed on the day of inspection was screened by the SPT and notified to HIQA within the appropriate timeframe.
• All compatibility assessments for the outstanding location had been completed and reviewed by the CSO, TL and PIC by the 27-11-2025.
• Impact risk assessments have been completed for all CMSNs impacted by the behaviors of concern of their peers.
• National Advocacy referrals have been submitted for all CMSNs in one location to ascertain their wishes in relation to their living environment and compatibility concerns.
• A reduction in the Capacity of the center to 11 CMSNs has been proposed as part of the re-registration process to provide assurances that there will be no further admissions into the center that may impact negatively on residents.
• A bespoke site-specific safeguarding training took place for one staff team, including agency, on 10-12-2025 which sought to enhance the team knowledge in relation to safeguarding and reporting processes.

Re-purposing of rooms in property one
• A change in proposed floor plans for one location has been submitted as part of the re-registration process. This change in floor plans facilitates the re-decorating of a downstairs sitting room to provide for a purpose designed activity room. The plan being to host specified activities each night of the week, tailored for individual likes with an indirect natural effect of separating CMSNs in line with their interests. Furniture was ordered on 27-11-2025 for this room. And deliveries have commenced.
• As part of the same amended floor plan submission, a sensory room is in the process of being developed. Occupational therapy recommendations have been received in relation to the most appropriate sensory equipment to consider. The room has been cleared of all previous contents on 26-11-2025 and bean bags have been purchased.
• As part of the same amended floor plans a small music/relaxation space is being created upstairs to provide a natural breakaway room for CMSNS who wish to remain in the hub of the home while also accessing some distance from the hustle and bustle of daily life. The room was cleared out on 20-11-2025 and seating was ordered on the 27-11-2025.

Property two

• In the second house there is currently two plans being considered; Plan one is a phased stage plan which was underway prior to the inspection date and refers to a change in routine for one CMSN in relation to where they spend their evening in the home and introducing a different way to seek out more appropriate social connection. The PIC has ensured the progress of this plan is being tracked by staff and reviewed by the CSO to ascertain its effectiveness. The most recent tracking was submitted to the CSO and is currently under review. The CSO's review will inform whether the plan is ready to progress to the next stage.
• A contingency plan is also being explored, should plan A not result in the desired effects, and this requires significant modifications to the home. The feasibility study was completed in October 2025. A builder has been identified and agreed to provide costings for the building element of the proposed project. Once costings have been secured, plan B will be proposed for funding to ensure it is approved and ready to proceed in event plan A is not successful.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/06/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/06/2026

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	30/12/2025
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.	Substantially Compliant	Yellow	30/01/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/01/2026

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2026