



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Comeragh Residential Services Waterford City
Name of provider:	Corlann
Address of centre:	Waterford
Type of inspection:	Announced
Date of inspection:	23 February 2026
Centre ID:	OSV-0005085
Fieldwork ID:	MON-0040613

About the designated centre

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

In this centre, a full-time residential service is available to a maximum of 5 adults. In its stated objectives the provider strives to provide each resident with a safe home and with a service that promotes inclusion, independence and personal life satisfaction based on individual needs and requirements. The centre comprises of one house. Residents attend off-site day services Monday to Friday. Transport to and from this day services is provided. Residents present with a range of needs in the context of their disability and the service aims to meet the requirements of residents with physical, mobility and sensory supports. The centre comprises a two storey house. Each resident has their own bedroom and share communal, dining and bathroom facilities (one bedroom is en-suite). The house is located in a mature populated suburb of the city and a short commute from all services and amenities. The model of care is social and the staff team is comprised of social care and care assistant staff under the guidance and direction of the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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
Monday 23 February 2026	09:00hrs to 17:00hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

This announced inspection was completed by one inspector of social services over the course of one day. It was carried out to assess the provider's regulatory compliance and to inform a recommendation to renew the registration of the designated centre. On this inspection, poor levels of compliance were noted in the areas of governance and management, staffing and medicines management. The levels of concern relating to medicines management resulted in an urgent action being issued to the provider during the inspection and an urgent compliance plan requested and submitted the day after the inspection. Areas where further improvements were required were also identified in safeguarding and the premises. These areas will be discussed further in the body of the report.

Since the last inspection the provider had applied to remove a premises from the designated centre. This had resulted in improved compliance in areas such as the premises and fire safety. The centre now comprises a two-storey premises in its own grounds, on the outskirts of Waterford City. A residential service is provided for up to five adults with an intellectual disability. There were three residents living in the centre at the time of this inspection and transition plans were in the early stages for a fourth resident. Each resident had their own bedroom and there were a number of communal spaces for residents' use including a number of bathrooms, sitting rooms and a large kitchen-dining-living room.

Over the course of the inspection, the inspector had opportunities to observe and engage with the three residents living in the centre. They told the inspector what it was like to live in the centre. The inspector also used a review of documentation and discussions with staff to capture residents' lived experience. This included meeting and speaking with the person in charge, the service manager who is a person participating in the designated centre (PPIM) and two staff. In addition, the regional service manager (PPIM) attended feedback at the end of the inspection.

On arrival, each resident greeted the inspector and welcomed them to their home. They invited the inspector to join them in the open plan kitchen-dining-living room and chatted for half an hour about what is important to them, how they liked to spend their time and about the important people in their lives. They were complimentary towards the supports provided to them by the staff and local management team. They spoke about how staff keep them informed and involved them in the day-to-day running of the centre. For example, they showed the inspector the board in the dining room to show what staff were on duty and spoke about menu planning.

Residents spoke about visiting or being visited by their family members and friends. Each resident spoke about having a mobile phone and using it to stay in touch with the important people in their lives. One resident spoke about their annual person-centred plan meeting which was being held in the afternoon in day services. They

spoke about how much they were looking forward to their family attending. Later in the day they returned with their family and spoke about how well their meeting went.

Residents spoke about taking part in table-top activities in their home, going out for meals and snacks together and going on holidays with their day services. One resident spoke about how much they enjoyed doing puzzles on their tablet computers.

Residents told the inspector they felt safe living in the centre and this was reflected in the questionnaire they completed in advance of the inspection. However, during the inspection one resident spoke about some difficulties they experienced sharing their home with a peer. They spoke about steps they and the staff team were taking to support everyone to stay safe. For example, they spoke about staff supporting them in communal areas, where possible, and them moving to other areas of their home, as needed. This will be discussed further under Regulation 8: Protection and Regulation 15: Staffing.

After spending time chatting with the inspector together, each resident separately showed the inspector their bedrooms and chatted about their many talents and skills. They showed the inspector some of their favourite possessions and their arts and crafts projects which were on display throughout their home. They showed their certificates and discussed some of their achievements. For example, one resident showed the inspector their certificate of attendance for a recruitment and selection training. They said they had been involved in interviewing staff and said they really enjoyed this. Another resident showed the inspector a letter and pictures relating to their achievements while taking part in the Special Olympics.

Throughout the inspection kind, caring and respectful interactions were observed between residents and staff. Staff were observed to be very familiar with residents' care and support needs. However, based on observations and a review of residents' assessments, the centre was not staffed to meet residents' assessed needs. There was a bus available to support residents to access their community and a risk assessment in place for residents to spend a short amount of time at home without staff supports; however, the inspector was informed that residents were choosing to go out together rather than staying home alone. Overall, based on discussions with residents and a review of rosters, residents' opportunities to go out individually were limited as there was only one staff on duty. These areas will be discussed further under Regulation 15: Staffing.

In summary, the inspector found that action was required to improve the safety of care and support provided for residents. This particularly related to medicines management, staffing and the implementation of control measures in open safeguarding plans. In addition, action was required by the provider to ensure effective oversight and monitoring in this centre. Some further improvements were also required to the premises.

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

Capacity and capability

Overall, the findings of this inspection were that the provider's systems for oversight and monitoring were not proving effective in this centre. Action was required to bring about improved compliance. This particularly related to medicines management, staffing, safeguarding and the oversight and completion of actions from audits and reviews. These areas will be discussed further, later in the report.

The management structure in the centre matched what was outlined in the statement of purpose. The person in charge had commenced in this centre in December 2025 and they received supervision and support from the service manager (PPIM). The person in charge is also identifies as such in another designated centre operated by the provider. They are assigned 16 hours per week for administration and oversight of the day-to-day running in this designated centre.

It was not demonstrated during the inspection that staffing numbers were in line with residents' assessed needs. In addition, some information required under Schedule 2 of the regulations was not in place in the three staff files reviewed.

Regulation 15: Staffing

Based on what the inspector observed, read and was told it was not demonstrated that staffing numbers were in line with residents' assessed needs.

Residents in this centre were supported by one staff on a sleepover shift. Staff were available to support residents during the waking hours of 07:30 to 23:00. During the week, as detailed in the statement of purpose, the house is generally closed between 09:30 and 16:30 as all residents attend day services.

While residents reported they enjoyed going to day services, the staffing supports were not in place should they not wish to attend. The inspector was informed by the local management team that if someone was unwell or needed to stay at home, arrangements could be made for staffing supports to be put in place on that occasion. One resident spoke with the inspector about how the service manager had supported them to get their state pension. They said they were retired but continued to attend day services five days a week. It was not clear if an alternative had been offered to them.

Based on a review of each residents' assessment of need and the current staffing compliment outlined in the statement of purpose, it was not demonstrated how one staff could provide the supports outlined. For example, the hours of supports listed for each resident in their assessment of need was 45 minutes of support in the morning, one and a half or two hours of support every evening and 30 minutes of support at night time. In addition, the inspector reviewed staff supervision records for the three staff who make up the staff them. Each of these referred to challenges for staff in relation to cleaning duties, the amount of documentation they needed to complete and the amount of time available to them to spend time with residents. In addition these records also referred to challenges relating to safeguarding residents. They each referred to residents' right to be protected from harm when not supervised by staff. This will be discussed further under Regulation 8: Protection.

The inspector reviewed a sample of three staff files. A full employment history was not in place in the three staff files reviewed. In addition, the qualification(s) for one staff were not available in their file.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector reviewed the staff training matrix in the centre and a sample of three staff files. These demonstrated that staff had completed training listed as mandatory in the provider's policy including, fire safety, managing behaviour that is challenging, safeguarding, manual handling, first aid, the safe administration of medicines and first aid.

The inspector also reviewed a sample of probation and supervision records for the three regular staff working in this centre. The agenda was focused on staff roles and responsibilities and residents' support needs. Staff had opportunities to discuss their strengths and skills and to identify if they required support relating to their roles and responsibilities. They had an opportunity to discuss training and personal development. In the staff supervisions reviewed, the inspector found that each one referred to the demands and pressures associated with their roles and responsibilities as the only staff on duty. This was discussed under Regulation 15: Staffing and Regulation 8: Protection.

Both staff who spoke with the inspector stated they were well supported and aware of who to raise any concerns they may have in relation to the resident's care and support, or the day-to-day running of the centre. They spoke about the provider's out-of-hours on-call system and the availability of the person in charge and PPIM should they require support.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector found that the provider's systems for oversight and monitoring were not effective in this designated centre. As previously mentioned, an urgent action was issued to the provider during the inspection and the provider was required to submit an urgent compliance plan to address urgent risks relating to medicines management within 24 hours of the inspection.

Based on discussions with staff and the local management team and a review of residents' assessments and plans, it was not demonstrated that the centre was resourced to ensure the effective delivery of care and support in line with the statement of purpose and control measures outlined in open safeguarding plans. In addition, there was a risk assessment in place for residents to stay at home but based on a review of fire drills in 2025, a drill had not been completed to demonstrate that residents could safely evacuate if they were home without staff support.

The person in charge had commenced in this designated centre in December 2025 and they were the third person in charge since May 2025. From a review of recent audits and reviews, some gaps were evident in oversight and monitoring since the last inspection. For example, there were no person in charge monthly reports in place for July, October or November 2025. In addition quarterly reviews of incidents had not been completed for July to September 2025 and this was completed retrospectively by the new person in charge. The person in charge monthly audit for January 2026 identified gaps in oversight, particularly relating to follow up and completion of actions and the oversight of residents' finances between May and December 2025.

The inspector reviewed two of the provider's six-monthly reviews for 2025 which contained conflicting information in relation to complete, ongoing and outstanding actions. For example, actions recorded as complete in the six-monthly review for May 2025 were marked as not completed in the subsequent one completed in October 2025. In addition, the provider's six-monthly review for October 2025 identified that there were five actions outstanding from the previous six-monthly and three actions outstanding from the provider's compliance plan following the last inspection in this centre in October 2024. These actions were not included in the action plan at the end of that six-monthly report. An action plan from November 2024 was also reviewed by the inspector. It contained 55 actions and six of these were marked as ongoing. These outstanding actions related to areas such as the premises and risk management. The inspector also reviewed the provider's annual review 2024. There were three actions outstanding and these will be discussed further under Regulation 17: Premises.

Overall, the inspector found that increased oversight was required to ensure that actions from audits and reviews were completed and leading to the required improvements.

Judgment: Not compliant

Regulation 31: Notification of incidents

Prior to the inspection, the inspector reviewed notifications submitted to the Chief Inspector of Social Services. In addition during the inspection they reviewed a sample of incident reports and completed a walk around the premises.

They found that the Chief Inspector had been notified of the required incidents. However, four notifications had not been submitted in line with the timeframe identified in the regulations. This included three allegations, suspected or confirmed of abuse for 2025 and one for 2026.

Judgment: Not compliant

Quality and safety

The inspector found that action was required to ensure that residents were in receipt of a good quality and safe service. This particularly related to medicines management and safeguarding.

Residents lived in warm, clean and comfortable home. A number of improvements had been made to the premises since the last inspection and more were planned.

Overall, the inspector found that residents were protected by the fire safety policies, procedures and practices in the centre. A number of fire safety works had been completed since the last inspection.

Regulation 17: Premises

The inspector found that efforts had been made and were ongoing to make the house appear more homely and comfortable.

Each resident showed the inspector their bedroom, which was decorated in line with their preferences. For example, one resident talked about picking the colour for their room which had just been painted. Residents had access to storage for their personal items.

There were a number of communal spaces available and residents spoke about their favourite parts of their home. For example, one resident spoke about using the sitting room to watch sports and another resident spoke about enjoying doing crafts in the other sitting room. There were pictures, photos and pieces of art created by residents on display throughout the house.

Some of the works completed since the last inspection included:

- Painting throughout the house.
- The installation of a new fireplace.
- The removal of an old shed. A new one had been ordered and was due to delivered.

Some of the outstanding work as detailed in the provider's latest annual review included:

- A bathroom renovation.
- Painting the outside of the house.
- The installation of a new kitchen and flooring.

There was no date identified for these works at the time of this inspection.

As part of the bathroom renovation mentioned above, a plan was in place to remove the bath and replace it with a walk-in shower. In the interim one resident was using a downstairs bathroom while waiting for the works to the bathroom upstairs to meet their needs.

Judgment: Substantially compliant

Regulation 28: Fire precautions

During the inspection, the inspector observed that emergency lighting, smoke alarms, fire-fighting equipment and alarm systems were in place. A number of fire safety works had been completed since the last inspection including the installation of additional emergency lighting. There were fire doors with swing closers in place. The inspector reviewed records for 2025 to demonstrate that quarterly and annual service and maintenance were completed on the above named fire systems and equipment.

The inspector reviewed a sample of five fire drill records for 2025. Drills were occurring frequently, and records reviewed demonstrated that evacuations could be completed in a safe and timely manner taking into account residents' needs and a range of scenarios. However, a drill had not been completed to demonstrate that residents could safely evacuate if they were at home without staff support. This is discussed under Regulation 23: Governance and Management.

Personal emergency evacuation plans for the three residents were reviewed and they were found to be sufficiently detailed to guide staff practice to support them to evacuate safely. The fire evacuation plan was on display and included different routes for evacuations.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that residents were not fully protected by the medicines management policies, procedures and practices in this centre. As previously mentioned, under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk relating to medicines management. The provider's response provided assurance that this urgent risk was adequately addressed.

Overall the inspector found that the registered provider had failed to implement appropriate storage, stock counts, and protocols relating to the administration, audit and oversight of controlled medicines in line with the provider's policy and national guidance. In addition, improvements were required to documentation and practices relating to the administration of other prescribed medicines.

Overall, it was not demonstrated during the inspection that some medicines were administered, as prescribed. Each residents' drug administration records were reviewed for 2025 and 2026 and discrepancies were found in each. For example, on four dates between April and August 2025 some prescribed medicines were not signed as administered to one resident. For another resident between December 2025 and January 2026 there was one occasion where a prescribed controlled drug was not signed as administered. For the third resident records between September 2025 and October 2025 demonstrated four occasions when prescribed medicines were not signed as administered.

The provider's audits and reviews were not proving fully effective at the time of this inspection. For example, recent audits had not picked up on documentation errors found by the inspector during the inspection. In addition the questions in the audit contradict what is contained in the provider's policy. For example, an audit question relates to two staff signing the controlled drug register and the provider's policy gives guidance for the administration of controlled medicines by one staff.

Judgment: Not compliant

Regulation 8: Protection

Residents were not fully protected by the policies, procedures and practices relating to safeguarding and protection in the centre.

The inspector spoke with the person in charge and the two staff on duty. They had each completed training in relation to adult safeguarding and were aware of their roles and responsibilities should there be an allegation or suspicions of abuse. They were also aware of the control measures outlined in two open safeguarding plans in the centre. However, based on observations by the inspector and a review of documentation it was not demonstrated how effective some of the control measures in the open safeguarding plans were at reducing presenting risks.

For example, a control measure in an open formal safeguarding plan was line of sight supervision by staff when two residents were with or near each other. Another control measure was for these two residents to be separated for short periods if staff felt there was a safeguarding risk. The inspector was informed that this control measure had not been implemented to date and was due for review by the provider's human rights committee as a rights restriction. In addition, one resident's safeguarding protection listed a protective measure of supervision when two residents are engaging in activities together. Due to the size and layout of the house and the current staffing levels it was not clear how these controls could be implemented effectively.

Another control measure in a formal safeguarding plan was staff use a laptop to complete documentation when supervision of residents was required. It was not possible to implement this control measure as a laptop was not yet sourced or available for staff.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Comeragh Residential Services Waterford City OSV-0005085

Inspection ID: MON-0040613

Date of inspection: 23/02/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: <ul style="list-style-type: none"> • A review of the centre's staffing complement will be undertaken to ensure that current staffing levels align with the assessed needs of residents. • The provider will conduct a full review of staff files to confirm that each file contains a complete and up to date employment history, along with all relevant qualifications. • The Compliance Manager has met with the HR Department and reiterated the requirements set out under Schedule Two. 	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: <ul style="list-style-type: none"> • A review of the centre's staffing complement will be undertaken to ensure that staffing levels remain aligned with the current assessed needs of residents. • A new system of oversight—the Monthly Report—has been implemented from February. This process ensures that all actions within the centre are collated, monitored, and tracked. The report is submitted by the PIC to the Service Manager, Regional Manager, and Director of Services, providing an enhanced level of oversight and accountability across the service. • A fire drill has been completed, as identified in the report, to demonstrate that residents can safely evacuate the premises should they be at home without staff support. 	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: <ul style="list-style-type: none"> • All incidents that require notification will be reported to the Chief Inspector in line with regulations. 	

Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <ul style="list-style-type: none"> • Quotations have been obtained for the bathroom renovation and exterior painting, in collaboration with the Building & Facilities Manager. These works will be scheduled and progressed to completion over the coming months. • With regard to the proposed replacement of the kitchen, this was identified during an annual review as a wish list item to be considered should funding become available for a cosmetic upgrade, rather than arising from any functional concerns. The maintenance team has reviewed the kitchen, and all cosmetic issues have now been addressed. The provider may revisit the option of a full kitchen replacement at a future stage when funding permits. 	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:</p> <ul style="list-style-type: none"> • A protocol has been developed to outline the management of Schedule 2 medication within the designated centre. • When any new medication is prescribed, staff will confirm with the pharmacist upon receipt whether it is a Schedule 2 controlled medication. • The Person in Charge will ensure that all Schedule 2 medication is stored securely in a double locked cabinet, and that all medications are checked and signed for in accordance with the relevant protocol and policy. • Staff administering medication will do so in line with the local Schedule 2 protocol and the Administration of Medication Policy. • The medication audit tool within the Administration of Medication policy will be reviewed to ensure it reflects the management of Schedule 1 and Schedule 2 controlled medications, including circumstances where staff may be working alone. • Internal monthly audits of controlled medication will be carried out to ensure full compliance with the required standards for the management, administration, and storage of these medications. • The Person in Charge is present in the designated centre three days per week, providing ongoing oversight and facilitating regular auditing of medication practices. • A risk assessment and management plan for the use of Schedule 2 medication has been implemented. 	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <ul style="list-style-type: none"> • A review of the centre's staffing complement will be undertaken to ensure that staffing levels are aligned with residents' current assessed needs, and to ensure that all safeguarding control measures in place can be implemented effectively. • A laptop is now available within the centre to support staff in completing documentation while maintaining appropriate supervision of residents. 	

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.	Substantially Compliant	Yellow	30/05/2026
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	30/04/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	30/09/2026

	kept in a good state of repair externally and internally.			
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	30/04/2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Red	24/02/2026
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	Not Compliant	Orange	31/03/2026

	centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/04/2026