Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Elm Green Nursing Home
Name of provider:	Costern Unlimited Company
Address of centre:	New Dunsink Lane, Castleknock, Dublin 15
Type of inspection:	Unannounced
Date of inspection:	28 April 2026
Centre ID:	OSV-0000133
Fieldwork ID:	MON-0050041

About the designated centre

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

Elm Green Nursing Home is located in Dublin 15 and is located in its own grounds. The centre is a two-storey purpose-built building and has 120 single bedrooms all with full en-suite shower rooms. Floors can be accessed by stairs and passenger lifts. Admission takes place following a detailed pre-admission assessment. Full-time long-term general nursing care is provided for adults over 18 years, including dementia care, physical disability and palliative care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	114

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 28 April 2026	07:30hrs to 17:00hrs	Sinead Lynch	Lead
Tuesday 28 April 2026	07:30hrs to 17:00hrs	Frank Barrett	Support

What residents told us and what inspectors observed

On the day of this unannounced inspection, the inspectors met with many residents and some visitors. All who were willing and able to converse with the inspectors provided positive feedback. Staff were commended for their kindness and caring attitude. Residents reported that they were 'happy living there' and that the 'staff are so kind'. While other visitors said that there had been an increase in staff present in the communal rooms lately and this had a positive impact on resident care and supervision.

Many visitors praised the physiotherapy service provided to residents, while one family reported that their relative had not yet been seen by the physiotherapist. However, before the inspection was completed the person in charge assured the inspectors that this resident would be assessed by the physiotherapist and the care provided as prescribed.

The centre was a large building laid out over two storeys and divided into two units on each floor, Oak and Laurel, with one unit designated as a dementia specific care unit. A large reception area, kitchen and dining room were on the ground floor alongside staff areas, smoking room, visitors room, hairdressing room and prayer room. Residents' bedrooms were located on both floors and communal lounges, dining areas and a library room were located throughout the centre. There were two courtyards and a garden accessible from the ground floor. On the first floor a roof garden was available for residents. Throughout the centre there had been new floor covering completed, while other areas of the centre were scheduled to be refurbished. These improvements in the premises ensured the areas were easily cleanable and trip hazards reduced. The hydrotherapy bathroom had been renovated and appeared to be a calm and relaxing environment.

While the premises was found to be generally clean and well-maintained, some issues persisted. The provider had a plan in place to remedy issues identified under Regulation 17: Premises at the last inspection, and these issues were being progressed within those time-lines at this inspection. However, infection prevention and control arrangements were not sufficient to ensure a clean and safe environment was provided at all times in all areas. For example, the cutlery trays in some kitchenettes were not clean and the back splash in one kitchenette was visibly dirty. This is further described under Regulation 27: Infection control in the report.

In addition, the management of fire precautions and oversight of staff practices with regards to fire safety was not sufficient to ensure a safe environment at all times for residents. Significant concerns in respect of compartmentation, fire alarm and evacuation routes were identified on this inspection, as further described under Regulation 28: Fire safety.

There was an activity schedule in place that reflected the activities taking place while the inspectors were present. The inspectors observed group activities, which the residents appeared to enjoy.

All residents who spoke with the inspectors said that the food was very good. They said that there was always a choice of meals, and it was always hot and tasted good. They confirmed that food and snacks were available at all times, including out-of-hours. The inspectors observed the dining experience at the lunch time meal. This was an unhurried and calm experience for residents. There were menus displayed on each table and residents were provided with three choices of a hot lunch. There was a selection of drinks and appropriate adaptable cutlery made available to residents if required. There were appropriate levels of staff to supervise and support residents in a discreet manner.

A record of complaints was maintained in the centre, and appropriate action appeared to be taken to address any concerns. There were two open complaints at the time of inspection. Residents spoken with confirmed that they would not hesitate to speak with a staff member if they had any complaints or concerns.

Some gaps were identified in respect of continence assessments and the relevant care planning arrangements to ensure residents were provided with appropriate continence wear.

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

Capacity and capability

Overall, this inspection found that Elm Green Nursing Home was a good centre with a strong management team and that residents received a good standard of person-centred, safe care. However, there were improvements required in relation to the premises, fire precautions, infection prevention and control and assessment and care planning, which are discussed in further detail in this report.

This was an unannounced inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended).

The registered provider is Costern Unlimited Company, which forms part of the Trinity Care Group. There were clear lines of accountability and responsibility in relation to governance and management arrangements for the centre. The person in charge was supported by a regional operations manager who was present on the

day of inspection. The person in charge was responsible for the local day-to-day operations in the centre and was supported in their role by the assistant director of nursing (ADON), clinical nurse managers, nurses, health care assistants, activity coordinators, domestic, laundry, catering and maintenance staff.

Staffing levels in place on the day of inspection were sufficient to meet the assessed needs of the residents. There was appropriate clinical supervision in place. The centre had established management systems in place to monitor information on adverse incidents involving residents, falls analysis, weight loss, and other significant care indicators. There were regular meetings at local and management level, with records of these available for review.

Staff training records were maintained to assist with monitoring and tracking completion of mandatory and other training completed by staff. A review of training records indicated that the majority of staff were up-to-date with mandatory training, with a small amount of staff, who were due refresher training, booked into upcoming dates.

Records of complaints were available for review and the inspectors reviewed a number of complaints received since the last inspection. Complaints were listened to, investigated and the complainant was informed of the outcome and given the right to appeal. Complaints were recorded in line with regulatory requirements. Residents and their families knew who to complain to if they needed to. There were two open complaints on the day of inspection.

The management of fire safety within the centre was reviewed during this inspection. The provider had implemented fire safety checks and systems to ensure residents were protected from the risk of fire. However, while there was a robust fire safety policy in place which set out the requirement for independent review of fire safety measures, this inspection identified a number of issues which were not addressed. Furthermore, many of these issues had been identified on a fire safety risk assessment (FSRA) carried out in December 2024. This FSRA identified some of the issues as category A or highest priority, however, there was no evidence in some cases that any mitigation or remedial works had been completed. This is discussed under Regulation 23: Governance and Management while fire safety generally is discussed in the quality and safety section under Regulation 28: Fire Precautions.

Regulation 15: Staffing

On the day of the inspection there were adequate staffing levels available to meet the needs of the current residents, taking into consideration the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

There was a training programme in place for staff, and records confirmed that staff were facilitated to attend training in fire safety, manual handling procedures and safeguarding residents from abuse. Staff also had access to additional training to inform their practice, in areas such as infection prevention and control, and training in the management of responsive behaviours.

Judgment: Compliant

Regulation 23: Governance and management

Management systems in place were not effective in all areas to ensure effective oversight of the quality and safety of service. For example:

- The provider had failed to act in a timely manner on significant concerns identified in a FRSA since 2024. Issues identified in that FSRA were not actioned within the timelines set out in the risk assessment. This included some high risk items such as containment measures, evacuation routes and fire certification. While the provider had a plan in place to rectify some of these issues, further action and resources were required to mitigate the highest risk items in a timely manner.
- Fire safety policy was not being adhered to in all areas of the centre such as the smoking policy, and storage arrangements.
- Immediate actions were given to the registered provider on the day of inspection in respect of ensuring the fire alarm system was in functional order and the management of escape routes. Providers' actions assured the inspectors that the immediate risks observed on the day were mitigated.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place, which was displayed throughout the designated centre. The records showed that complaints were recorded and investigated in a timely manner and that complainants were advised of the outcome.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing policies and procedures as set out in Schedule 5. However, not all policies were implemented in practice as detailed further under Regulation 23: Governance and management and Regulation 27: Infection prevention and control.

Judgment: Substantially compliant

Quality and safety

Overall, residents were supported and encouraged to live a good quality of life in the centre, however the deficits in management and oversight of fire safety and gaps in the oversight of premises and infection prevention and control adversely impacted the quality and safety of the service provided.

Residents' care plans and daily nursing notes were recorded on an electronic documentation system. The inspectors reviewed a sample of resident care plans and spoke with staff regarding residents' care preferences. There was evidence that they were completed within 48 hours of admission and reviewed at four monthly intervals. However, residents' individual assessments in relation to continence were not appropriately assessed as detailed further under Regulation 5: Individual assessment and care plan.

Residents had access to a full multi-disciplinary team. There was no delay in referring residents to members of the team and, as outlined under Regulation 6: Healthcare, the recommendations made by various disciplines were implemented in practice.

Residents had access to a range of media, including newspapers, telephone and TV. There was access to advocacy with contact details displayed in the centre. There were resident meetings to discuss key issues relating to the service provided.

There was an activity teams in place and the schedule for activities was displayed around the centre.

There were large external spaces available on both levels to residents, including balcony areas off the first floor dining space. Some other communal spaces were used for therapies during this inspection. The centre was found to be mainly clean and well-organised overall. However, further improvements were required to prevent the risk of cross-infection as detailed under Regulation 27: Infection control. Other issues such as storage, and the use of some of the communal space were

highlighted on this inspection which required attention. These issues are discussed under Regulation 17: Premises.

The measures in place to protect residents from the risk of fire required significant improvement as identified on this inspection. While there were fire safety systems such as a fire detection and alarm system, fire suppression systems in the kitchen, fire extinguishers throughout and emergency lighting in place, issued were noted which required immediate attention. The fire alarm panel was showing a fault on the display, and the narrative on that display indicated that the system had been silenced. Inspectors required assurance before leaving the centre that the fire alarm was in working order and would activate on the detection of a fire. A service provider was called in and rectified the issue during the period of the inspection.

Another significant concern was noted with fire exit directional signage which directed evacuees into an internal courtyard with no exits. This issue was further compounded by the mechanism on the door which did not allow an evacuee entering this courtyard, to open the door from the inside. An immediate action was given to the registered provider to cease such arrangements and that staff be informed that this route, though indicated as an exit, should not be used in the event of a fire. Further concerns were noted with compartmentation within the centre. As the centre relied on progressive horizontal evacuation in a fire event, which allows horizontal movement of evacuees to a place of relative safety, compartmentation and separation of these compartments was vital. This compartmentation allows for the protection of the escape route, and safe time at the next compartment. However, significant compartmentation issues were noted in several areas which compromised the effectiveness of the separation and the escape route. These and other fire safety concerns are noted under regulation 28: Fire Precautions.

Regulation 17: Premises

The previous inspection report had identified issues which were still being rectified as per the providers timescale for these works. For this reason, the issues raised in this report relate only to issues which had not been part of the compliance plan for the last report.

Improvements were required of the registered provider to ensure that the premises is used in line with the Statement of Purpose and the floor plans for which it is registered. For example:

- Lounge 3 on the first floor was registered as a lounge, however it was being used for chiropody services on the day of inspection meaning that this communal space was not available to residents.

Improvement was required of the registered provider, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Resident sinks within en-suite bathrooms were not provided with a plug for residents use to allow them to effectively use the sink.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents informed inspectors that there was a good choice of food available to them. They had the option of snacks whenever they wished. The residents were provided with choice at all mealtimes.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018), however further action is required to be fully compliant. This was evidenced by:

- The cutlery storage unit required cleaning as sediments of food were observed by the inspectors.
- The back-splash in one of the kitchenettes required cleaning as reminiscences of food were evident.
- The flusher in one of the sluice hoppers was not working.
- There were bottles of detergent stored in an unlocked press in one of the unit kitchenettes which may pose a risk to residents consuming these.
- Storage practice required review as some storage areas were observed to be overfilled with mixed items. There were items stored on the floor also making cleaning of the area difficult and contrary to the policy of the provider.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire and to provide suitable fire fighting equipment for example:

- Electrical and communications distribution boards were concealed behind non fire-rated partitions and fitted on escape routes. This introduced a fire risk that could impact on the escape routes.
- Storage practice was impacting on the risk of fire with flammable items such as aerosols stored alongside combustible items such as cardboard and paper products.
- Assurance was required that fire extinguishers in various locations throughout the centre, were serviced in line with the current requirements, including the use of a discontinued type of extinguisher foam.
- Smoking was being facilitated outside an exit door from a day room in the Laurel wing. This area was not designated as a smoking area, and did not have the adequate fire prevention and extinguishers or a call-bell.

The registered provider did not provide adequate means of escape including emergency lighting for example:

- The route to safety was not appropriate in all areas. One ground floor exit which was signposted as a fire escape, led into an internal courtyard with no exit. Once inside courtyard, the door could not be opened from that side as there was no handle. This was part of an immediate action and assurances were received following inspection that all staff were informed of alternative arrangements.
- Emergency lighting and emergency directional signage was inadequate. Some external emergency lights at exit doors were not in working order. One ground floor exit led to a footpath surrounding the side of the building. There was a grassed embankment adjacent to this footpath, which required evacuees to use the footpath. There was no emergency lighting along this route to indicate the way to the assembly point. There was a lack of emergency lighting and directional signage on the first floor balcony where a smoking shelter was fitted.
- One escape route led to a courtyard door, however, there was a large step outside the door which would not be readily usable by residents with mobility aids, or infirm walking residents. This would also present difficulties for mattress evacuation in the event of a fire.

Staff knowledge of fire precautions and evacuation strategies required review, as follows:

- While there were regular fire drills completed at the centre, records showed that staff were not evacuating the entire compartment during fire simulations, and there were a lack of understanding of the requirements of vertical evacuation using the stairs.
- Floor plans posted on the walls did not outline escape routes, compartment boundaries or the assembly points, to assist evacuees in the case of a fire.

The registered provider did not make adequate arrangements for containing fires. For example:

- Significant containment issues were identified. For example, some fire doors were sticking in the floor following flooring repairs. Two door closers to the day room in the Laurel wing were preventing the doors from closing automatically on activation. A doorgard door holder was beeping indicating that the battery was failing. This could impact on fire smoke and fume containment in the event of a fire. Many of the fire door concerns were noted on the FSRA from 2024.
- There was a ventilation grille in the wall over the door to the kitchenette which compromised the fire rating of the wall as it did not appear to be capable of containing fire smoke or fumes
- The fire shutter fitted in the wall between the main kitchen and the dining room did not appear to have any smoke containment measures fitted to it.
- An electrical riser in the escape corridor near the dining room was not fire sealed over the head of the door or around the frame. The ceiling in the corridor was a loose suspended type ceiling which would not contain fires. This meant that there was no effective containment between the electrical riser and the escape route.
- Rooms containing the hot water tanks for individual bedrooms in the Laurel wing were not sealed around the door frames.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Notwithstanding that each resident had appropriate care plans in place, further improvements were required in relation to continence assessments. For example; continence assessments were incorrectly completed which in turn did not ensure that residents received the correct absorbency of continence wear which may lead a resident to develop skin breakdown.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider had ensured that all residents had access to appropriate medical and health care, including a general practitioner (GP), physiotherapy, speech and language therapy and dietetic services.

Judgment: Compliant

Regulation 9: Residents' rights

Residents’ rights were upheld in the centre and all interactions observed during the day of inspection were person-centred and courteous.

Residents had access to meaningful activities. The activity schedule was on display and residents were involved in person-centred activities throughout the day.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Elm Green Nursing Home OSV-0000133

Inspection ID: MON-0050041

Date of inspection: 28/04/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: •Issues identified relating to fire containment measures, evacuation routes and fire certification will be actioned fully to mitigate the highest risk items in a timely manner. •Fire safety policy will be fully adhered to in all areas of the center by adhering to the smoking policy and storage arrangements. There is a plan to provide additional fire safety measures to the external area outside Ground Laurel Day room, where some residents use for smoking. The storage of items in the storeroom opposite the CNM office was reviewed and any items stored on the floor were removed. The items were reviewed and ensured that these were arranged and stored appropriately. •The fire alarm panel showed fault on the morning of the inspection, the cause of it was a broken manual call point in the link corridor. The PIC had contacted the service contractor in the morning, who arranged an engineer to check the alarm system onsite on the same day. The engineer serviced and repaired the manual call point, and the alarm panel was fully functional by 5 PM. A service report was received from the contractor, which is logged in the fire book.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:	

Fire safety policy will be fully adhered to in all areas of the center by adhering to the smoking policy and storage arrangements. There is a plan to provide additional fire safety measures to the external area outside Ground Laurel Day room, where some residents use for smoking.
The storage of items in the storeroom opposite the CNM office was reviewed and any items stored on the floor were removed. The items were reviewed and ensured that these were arranged and stored appropriately.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The use of Lounge 3 on the first floor was reviewed following the inspection. It is implemented that Lounge 3 is no longer used for chiropody service, and it will be made available as the communal space for the residents always. The ensuite sinks that do not have a plug were reviewed by the maintenance team, these are ordered and will be installed.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The cleaning practice and storage of items in the kitchenettes were reviewed with the Head chef, the catering team and the unit staff. The Head chef and the managers conduct frequent walk arounds to ensure that the kitchenettes are clean, and no items stored inappropriately in any kitchenettes.

The flusher on the sluice hopper in Ground Laurel unit was replaced with a new one by 5th May 2026.
The storage of items in the storeroom opposite the CNM office was reviewed and any items stored on the floor were removed. The items were reviewed and ensured that these were arranged and stored appropriately.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Electrical and communications distribution boards were reviewed by the service contractor and EOBA Fire consultants and both have agreed that these are low voltage and does not require to be concealed behind fire cabinet. The maintenance team has secured the document relating to the same.
The storage of items in the storeroom opposite the CNM office was reviewed and any items stored on the floor were removed. The items were reviewed and ensured that these were arranged and stored appropriately.
There are 92 foam extinguishers in the nursing home. The management has contacted the service contractor and discussed the replacement of the same. It is agreed that a phased replacement of all foam fire extinguishers will be carried out, during each service visit, to be completed by June 2027.
There is a plan to provide additional fire safety measures to the external area outside Ground Laurel Day room, where some residents use for smoking.

The ground floor exit opposite to resident's smoking area, which was signposted as a fire escape, led into an internal courtyard was reviewed by the management and the service contractors. The signage on the door was removed, thus, to avoid any misleading information in case of an emergency.
Emergency lighting at some exit doors which were not working, the need of emergency lighting on the first-floor balcony and the need of emergency directional signage outside one of the ground floor exit doors and the first-floor balcony were reported to the service contractors. This will be completed by August 2026.
The step outside the door to the internal courtyard will be levelled to facilitate ease of access for the residents and to aid in need of mattress evacuation in the event of a fire.
The management have reviewed the process of simulated fire drills to include evacuation of the entire compartment and complete vertical evacuation.
Appropriate Floor plans will be posted on the walls outlining escape routes, compartment boundaries and the assembly points, to assist evacuees in the case of a fire.
The doors that were not closing properly on the day of inspection were repaired by the maintenance team following the inspection and all doors in the home are fully functional now. The two door closers to the day room in the Laurel wing were repaired and the doors closes automatically on activation. The doorgard door holder on one door in Ground Oak was removed following the inspection and the magnet door release was placed.
The ventilation grille in the wall over the door to the kitchenette in Ground and First Oak were blocked permanently, as there is extractor fan fitted in the kitchenette.
The fire shutter fitted in the wall between the main kitchen and the dining room will be serviced by the service contractor and will ensure that smoke containment measures fitted to it.
The electrical riser in the escape corridor near the dining room will be serviced by the service contractor to ensure that they are fire sealed over the head of the door and around the frame. The ceiling in the corridor was fixed by the maintenance team.
The doors of the rooms containing the hot water tanks for individual bedrooms in the Laurel wing were reviewed and are fire sealed around the door frames. However, it is identified that the architrave needs to be reinstated. This will be completed by the

maintenance team.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Following the inspection, the PIC and ADON met with all nurses in the nursing home and re-educated on completing the continence assessments for residents appropriately. Re-educated the staff the impact of this assessment on the continence care of the residents. All residents assessments are currently being reviewed as part of 4 monthly review and will be completed by 30.06.2026

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 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	29/04/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	01/10/2026

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	05/05/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/07/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre	Substantially Compliant	Yellow	30/08/2026

	and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/07/2026
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/08/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/06/2026