



**Health
Information
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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:	Carysfort Nursing Home
Name of provider:	Ardancare Limited
Address of centre:	7 Arkendale Road, Glenageary, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	20 May 2026
Centre ID:	OSV-0000022
Fieldwork ID:	MON-0050159

About the designated centre

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

Carysfort Nursing Home is located in Glenageary Co. Dublin. The designated centre is registered to provide accommodation for a maximum of 49 residents. The centre provides accommodation for both female and male residents aged 18 years and over. The centre provides 24 hour nursing care to short term convalescence/ transitional care, respite care, long term care and day care. Bedroom accommodation comprises 15 single, 10 twin, two three-bedded and two four-bedded bedrooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48
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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
Wednesday 20 May 2026	11:00hrs to 20:20hrs	Niamh Moore	Lead
Wednesday 20 May 2026	11:00hrs to 20:20hrs	Laurena Guinan	Support

What residents told us and what inspectors observed

This was an unannounced inspection, carried out over one day by two inspectors of social services. The inspectors met with many of the residents, staff and six visitors during this inspection. Inspectors received largely positive feedback on residents and their loved one's lived experience of Carysfort Nursing Home.

Upon arrival at 11:00am, inspectors commenced a walk around of the centre. Following the morning walkabout, an introductory meeting was held with the person in charge and one of the company directors, where the purpose of the inspection was set out.

The designated centre was registered for 49 residents, with 48 residents on the day of this inspection. The centre had two buildings, the main building contained residents' residential accommodation. This was set out across three floors within 15 single bedrooms, 10 twin bedrooms, two three-bedded bedrooms and two four-bedded bedrooms. On the ground floor of the main building, there were communal spaces such as the front sitting room and a second large room that was divided into a dining room and a day space. Inspectors observed that residents mostly occupied this room throughout the day. The first floor had a sitting and dining room, and was used for meal-times by four residents. The second building was referred to as "the Bungalow", which contained some office and storage space, and also communal spaces available for residents such as a living room and a conservatory. This building was not seen to be used by any residents or visitors during the inspection, and many residents told inspectors that they were unaware that this space was available to them.

As previously stated, inspectors observed that most residents spent their day in one day room on the lower ground floor, with inspectors observing 32 of the 48 residents, and a further four staff members, in this area at one time in the afternoon. A large proportion of visitors spoken with also stated that this was the room where they joined their loved ones for their visits. Inspectors found that all planned activities occurred in this area, with residents observed seated around the perimeter of the room, and in some cases arranged in rows. Inspectors observed that there was no designated communal area available to facilitate therapy activities for residents who required, or preferred, a quieter environment.

Improvements were noted in some areas of the premises and in fire safety. For example, the provider had commissioned a fire safety risk assessment, a new fire alarm system was fitted into the Bungalow, and maintenance works to include painting was occurring during this inspection. One four-bedded room was being painted, but inspectors saw that there was no signage to alert people before they entered the room. The beds had not been covered, and paintings which were

removed from the walls were placed on one of the residents beds. The residents' belongings were also exposed on their dressers.

Inspectors saw that action had been taken with the reconfiguration of most multi-occupancy bedrooms. Inspectors saw that new wardrobes were purchased, privacy curtains were re-arranged with some bedrooms having new curtains, and some rooms had sinks moved to allow residents additional personal space. Residents spoken with said they were happy with their bedrooms. Notwithstanding these improvements, inspectors noted that two bedrooms did not fully uphold residents' rights to privacy due to missing privacy curtains, and the location of wardrobes which will be further discussed within this report.

In addition, some aspects of the premises such as the availability of accessible bathrooms, and safe outdoor space had been raised in inspection reports since May 2024, and inspectors found there was limited action taken to address these areas. For example:

- The lower ground floor had bedrooms for 11 residents, and this area was where the majority of residents spend their day, as observed by inspectors and confirmed by residents and visitors. There was access to one assisted shower room and two toilets which were not fully suitable for residents with reduced mobility requiring aids. For example, these toilets had half-doors, and inspectors observed a resident use one of these toilets with the door open. Staff walked by and did not close the door. The resident stated they found the door hard to close. Access to other toilets on the ground floor involved the use of steps or a chair lift.
- The ground floor had bedrooms for 10 residents and also contained another day space. There was one assisted shower room, and one toilet that was not fully suitable for residents with reduced mobility requiring aids. The door to the toilet opened onto the narrow corridor and was beside the door to a bedroom. Access to the shower room and toilet was through a four bedded room or through a corridor with two doorways.
- The first floor was also split into two levels with access by stairs or a chair lift. This created difficulty in accessing assisted bathrooms for this floor. For example, in one area there were bedrooms for 15 residents and one accessible bathroom. A second toilet was available, but this required residents to be mobile and able to use steps independently.

Residents had access to a secure garden from the day room and from some of the bedrooms, although the bedroom access routes were only used as emergency escape routes. The garden was sloped, with raised areas in parts. Some of the pathways were uneven, with tree roots protruding on an earthen path. These posed significant potential for residents to slip or fall, and the area would be difficult for residents with impaired mobility, or residents who used mobility aids, to navigate. One resident told the inspectors that although they loved spending time in the garden they 'wouldn't chance it' on their own and would wait for staff to assist them. The threshold of the day room door into the garden was raised, which made it difficult to navigate, and the door was found locked by inspectors. When this was brought to the attention of staff, they were unable to say why it was locked, and the

inspectors waited for staff to locate the key. On seeing this, one resident complained that the door was locked, stating that it should not be locked.

Inspectors saw examples of inappropriate storage within the centre. The staff break room was unlocked and inspectors observed three trays of residents' dietary supplements stored in this room, and storage of unlabelled food for residents' meals in the staff fridge such as carrots and lemon mousse. Additionally, there were two chairs in the process of being varnished in this area.

Inspectors observed that staff were attentive and responsive to residents' needs and when speaking with inspectors, they demonstrated familiarity with residents' assessed needs and communication requirements. However, some staff spoken with were not fully-confident regarding the evacuation methods for different fire scenarios.

Friends and families were facilitated to visit residents, and the inspectors observed many visitors in the centre. Feedback from visitors spoken with was very complimentary about the care their loved ones received, with praise including the care, and communication from management and staff that supported their relatives in the centre.

Residents had access to newspapers, televisions and radios in their bedrooms and in the communal areas. Information regarding advocacy services was displayed in the centre, and inspectors were informed that residents were supported to access these services if required. Inspectors observed some small group activities taking place, such as residents being supported to participate in sensory fidget activities, while some residents watched movies on tablet devices.

Inspectors observed the mealtime experience for residents. Most residents dined in the ground floor dining room and inspectors saw there were two sittings to cater for the number of residents in this area. Residents who were not dining were sitting in the day room section of this area. There were four residents who dined in the dining room on the first floor. Inspectors saw this was a relaxed and sociable experience, with residents enjoying each other's company as they ate, while engaging in conversation. There was a choice of meals displayed on written menus, with a choice of two options for their main meal such as corned beef and turkey. However, two residents said they were not offered a choice and were handed corned beef, stating they would have preferred the turkey option. Staff spoken with were unsure how residents' choice was recorded, however inspectors saw that both residents were offered a change of meal with one resident taking this option. A choice of drinks was available throughout the meal-times. There was a sufficient number of staff present during the meal-time to assist residents. Residents said they were happy with the meals, including the temperature of meals. One resident said they loved the soup.

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

Capacity and capability

Overall, there were management systems in place to ensure residents were provided with quality care and support. However, not all areas of the service were effectively monitored and consistent, particularly relating to the oversight of the premises and the impact this had on residents' rights and fire precautions.

The purpose of this unannounced inspection was to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the compliance plan from the previous inspection which was held in October 2025, information received by the Office of the Chief Inspector since then, and to inform the upcoming renewal of registration for the designated centre.

Ardancare Limited is the registered provider for Carysfort Nursing Home. There are four company directors with two of these directors present during this inspection and who provided support to the person in charge.

The person in charge was supported in their role by an assistant director of nursing and clinical nurse manager. Additional staff available included staff nurses, healthcare assistants, activity staff, catering, housekeeping, laundry and a finance and contract officer. On the day of the inspection, there was sufficient staff available to attend to residents' needs.

There was a suite of training available to staff and the inspectors saw a high compliance in areas such as fire safety, managing behaviours and medication management.

All the requested documents were available to inspectors for review and found to largely comply with legislative requirements.

The quality and safety of care was monitored through oversight systems such as audits, committees and meetings. Key information used to support the monitoring of clinical care practices in areas such as falls, restraint use, medical errors, wounds, safeguarding and complaints were discussed through these forums. However, inspectors found that these systems did not always identify areas that required improvement, and in some cases despite improvements being identified they were not fully actioned. For example, while inspectors acknowledged that the provider had made progress with most areas on the compliance plan since the last inspection, this inspection identified ongoing weaknesses in the overall governance and management of the service, which resulted in repeated non-compliance with the regulations on premises, fire precautions and residents' rights.

Inspectors reviewed the annual review report of the quality and safety of care delivered to residents in 2025. This report incorporated feedback from residents and

families, and there was a quality improvement plan for 2026. The provider outlined that their focus for 2026 remained on compliance, quality improvement, and enhancing residents' experience within the centre.

The measures in place to safeguard residents and their belongings while painting work was underway was discussed with the person in charge, who provided inspectors with a risk assessment for the work. Measures to reduce the risk such as appropriate signage and protection of residents' beds, while noted in the risk assessment, had not been implemented. There were no detailed measures to protect residents' belongings, or arrangements to provide the residents with alternative space to rest while their room was unavailable. This was addressed with the person in charge, who said they would update the risk assessment to include these measures, and communicate them to residents, staff and contractors. The person in charge also stated that there was a schedule of refurbishment planned, but they had no access to it and that the schedule was only available to one of the directors. The person in charge acknowledged that due to the different levels in the main building, a separate risk assessment with alternative rest and toileting arrangements specific to each room was required in advance of the work commencing, and the measures communicated to residents, staff and contractors to ensure they would be fully implemented.

Registration Regulation 4: Application for registration or renewal of registration

An application for registration renewal was submitted to the Chief Inspector of Social Services within the required time-frame and was in review at the time of this inspection.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill mix to meet the assessed needs of the residents in the designated centre, on the day of inspection.

Judgment: Compliant

Regulation 19: Directory of residents

The provider had a paper-based directory of residents in the designated centre. This directory recorded the information required under Schedule 3 of the regulations,

such as where there were any admissions and discharges of residents, and contact details for next of kin and the resident's general practitioner.

Judgment: Compliant

Regulation 21: Records

The registered provider ensured that the records set out in Schedules 2, 3 and 4 of the regulations were safely stored in the designated centre and were available for inspection. This included a record of current registration for all staff nurses working within the centre.

Judgment: Compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that protected residents against injury and other risks, such as loss or damage to property.

Judgment: Compliant

Regulation 23: Governance and management

While the registered provider had some assurance systems in place regarding the quality and safety of the service, a number of areas were identified that required action. This was evidenced by:

- The provider had developed a timebound action plan to address the issues identified on previous inspections regarding the premises, this included increasing residents accessibility to assisted bathrooms and the outdoor area. However, inspectors found that these areas remained an issue for residents and had not been fully addressed within the timeframes committed to in their compliance plan.
- Inspectors were not assured that when residents voiced dissatisfaction with parts of the service, that this information was escalated to the complaints officer to ensure that appropriate action was taken. Inspectors were told by residents of three concerns that had been raised with staff and management which were not documented or followed up with the resident concerned.
- Environmental audits were not identifying all areas of concern. For example, unlabelled shower sponges were observed in shared bathrooms and therefore

could not be identified as belonging to a specific resident. This was not identified in audits and therefore no action was taken to reduce the risk of residents sharing these items.

- There was poor oversight to ensure the implementation of the control measures identified in the risk assessments for the building works which were ongoing. For example, painting was occurring throughout the day in one of the four-bedded rooms and there was no oversight to ensure residents belongings were protected during this work, nor was there alternative arrangements made for those residents to rest in a quiet space throughout the day. In addition, tools were seen left unsupervised in a communal area, creating a safety risk to residents.

Judgment: Not compliant

Quality and safety

Residents living in Carysfort Nursing Home were seen to receive a high standard of care from staff who were familiar with and responsive to their needs.

Notwithstanding this, the inspectors saw gaps in the areas of care plans, visiting, residents' rights, the premises, staff knowledge of fire evacuation procedures, and the storage of medication.

The inspectors reviewed a sample of residents' care plans with a focus on pressure area care and the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Validated assessment tools were used to develop care plans within 48hrs of admission, and these were reviewed every four months, or as required. Residents who had impaired skin integrity were referred to a General Practitioner (GP) and Tissue Viability Nurse (TVN) when required. However, inspectors saw an instance where a resident's dressing frequency was not being followed as per TVN recommendations. This was discussed with the assistant director of nursing who said that the frequency of dressing changes had been reduced as the wound was healing. However, there was no evidence of an updated assessment being completed to inform this decision or whether it was on the advice of the TVN, and it was not documented in the resident's care plan. The dressing records varied from two to six days, so it was not possible to ascertain what the current dressing frequency was, and the most recent photographic evidence to track wound improvement was dated two weeks prior to the inspection.

Residents who displayed responsive behaviours had care plans that were person-centred and detailed potential triggers and de-escalation techniques, and referrals to GP and psychiatry of later life were made, with regular review as needed. Residents who required enhanced supervision were seen to receive one-to-one support, and

the staff spoken with were knowledgeable about the residents they were caring for. Staff had received training in managing these behaviours.

The inspectors saw many kind and respectful interactions throughout the day, and families spoken with said that their loved ones were always included in activities. The inspectors saw staff engaging residents in group and one-to-one activities. However, these activities were all seen to take place in the day/dining space on the lower ground floor. This space was fully occupied for the duration of the inspection and was observed to be noisy and busy at times, with many residents spending their entire day in the one area. This had been raised at a residents' meeting, but there was no action plan to address this, and it was noted that the resident who voiced the concern was 'quite happy to go to their bedroom for peace and quiet'. This did not address the issue for the remaining residents and those who shared twin, triple and four-bedded rooms. Additionally, there was no evidence that residents were informed of additional spaces, registered as communal spaces, available for their use should they require a quiet space.

A record of five residents' meetings were reviewed by the inspectors. These were seen to be attended by between nine and 12 residents, however, some residents spoken with said that they were not aware that residents' meetings were held. Some residents expressed concern that at times, they were not given full information to make informed decisions. For example, a number of the residents' bedrooms had exit routes, and the provider had consulted with the resident or their families to obtain consent to allow other residents to use the exit in the case of an emergency. However, the consent form also stated that due to the emergency arrangements in place, these rooms could not be fitted with locks. One resident said that they had not been made aware of this when signing the consent form.

Another resident expressed significant upset that after accessing the in-house hairdresser, they felt the cut was of very poor quality. They told the inspectors that had they known that the hairdresser was a staff member and not a trained professional hairdresser, they would have accessed a hairdresser in the community. This was not documented in the residents' records, despite it causing upset to the resident, and known to staff. This will be further discussed under Regulation 9: Residents' rights.

The inspectors spoke with a number of visitors during the inspection, and they were highly complementary of the care their loved ones received. One visitor said it was 'like a home from home', and staff were praised for their communication with families. Those spoken with said that they were promptly updated on changes in their loved one's condition, and they found this reassuring. There was a visitors' policy in place that was in line with the regulations, however, the policy did not refer to all the communal areas available for residents to receive visitors. A conservatory and sitting room located in the Bungalow on the grounds of the centre were not identified in the policy. No residents or visitors reported using this space for visits, and some residents were not aware of it. Throughout the day, the Bungalow was not seen to be used by residents or families, and there was a large supply of household and hygiene products stored in the sitting room, which did not make it an aesthetically pleasing place to relax in. The person in charge said that the supplies

had been there for some time. Additionally, an upstairs dining/sitting area was not identified in the visitors' policy, and this area was only seen to be used by four residents during mealtimes. Inspectors observed that visitors were received in the front sitting room, or in the day room where the majority of residents spent their day.

Inspectors acknowledge the provider had completed some maintenance works since the last inspection, to include ensuring call-bells were installed in the communal spaces in the Bungalow, that call-bells were working in the smoking area, and the decking in this area was also repaired. However, due to the age and the configuration of the centre, inspectors found that many areas were not fully accessible for residents due to requiring steps, or where there was slopes and uneven thresholds. This and other required maintenance works are further discussed under Regulation 17: Premises.

There had been significant measures taken to improve fire safety in the centre. The registered provider had undertaken a fire safety risk assessment, and was awaiting a review of the actions taken in response to this. A gas detection system had been installed in the laundry, and a fire detection system had been installed in the bungalow. A schedule of fire drills to include vertical evacuation had been implemented, and all staff were compliant with training. The inspectors spoke with a number of staff and some did not display a good knowledge of the procedure to follow when the fire alarm sounded. Staff spoken with said that while they had been educated in the use of fire evacuation aids such as ski sheets and evacuation chairs, they were not used in practice during fire drills and they would not feel confident using them. Regular walkabouts were conducted to ensure that all fire escape routes were free of obstruction, however one fire escape route located in a resident's bedroom was seen to be partially blocked with walking aids. The resident confirmed that the aids were habitually stored there. This was discussed with management who said that they would review the situation.

Regulation 11: Visits

The registered provider had not ensured that residents and their families were familiar with all the areas available for their use during visits. 34 of the 49 residents living in the centre were in shared occupancy bedrooms, and a large number of visitors were seen coming and going during the day. Only two of the available areas were identified in the visitors' policy and in regular use for visiting. One of these areas was heavily used for the duration of the inspection, which meant that only one private area was in use. This did not ensure that all residents would have access to a suitable private area to receive visitors in.

Judgment: Substantially compliant

Regulation 17: Premises

Some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows:

- Some equipment in shared bathrooms were seen to be rusted, such as toilet seat risers and grab rails.
- A wall-panel was damaged, and a grab rail was visibly loose and not secured to the wall in a shared bathroom, making it unsafe for residents to use.
- Four chairs in the garden had holes on them from cigarette burns.
- The carpet throughout the centre, including in communal spaces and on corridors, was badly stained.
- Toilets, bath and shower rooms required review to ensure they were accessible and suitable for the residents intending to use them. For example, many were seen to only be suitable for independent residents with limited mobility concerns. However, during this inspection 44 percent of residents were assessed as high or maximum dependency. Inspectors were told by two residents that when they were using the ground floor, they often returned to their bedrooms on the first floor to use the toilet due to the inaccessibility of toilets. Additionally, the limited space available in some bathrooms made it difficult for residents to dress after personal care, particularly for those using mobility aids or who required assistance of one to two staff with these activities.
- Two bathrooms lacked ventilation posing a risk of mould developing.
- The outdoor space was not suitable for residents as there were many trip hazards observed.
- There was inappropriate storage observed. For example:
 - many shared bathrooms, which were limited in space, also stored commode chairs.
 - the living room in the Bungalow had stock stored on the floor such as clinical supplies and kitchen supplies.
 - there were items from maintenance works left unsupervised in the garden, including plasterboard in the smoking area.
 - the staff break room was seen to be used to varnish chairs. Medication and food which was prepped for the lunch-time service was also stored in this area.

Judgment: Not compliant

Regulation 28: Fire precautions

This regulation was not fully reviewed during this inspection, as the registered provider had committed in their compliance plan from the previous inspection to addressing all areas of concern by 31 May 2026. However, inspectors saw that many

improvements had been made, for example the provider had commissioned a competent person to complete a fire safety risk assessment. The provider confirmed that all actions were nearly completed and that a report confirming sign-off from the competent person would be provided to the Chief Inspector. Notwithstanding this, there were areas which did not provide adequate precautions against the risk of fire. This was evidenced by:

- Staff did not display a good understanding of fire evacuation procedures, or confidence in the use of fire evacuation aids.
- Use of ashtrays in the smoking areas was not enforced, as seen by numerous cigarette butts in both areas, and one of the smoking areas without an ashtray.
- A fire escape route was partially blocked by mobility aids.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured that all medicinal products were stored securely as evidenced by nutritional supplements stored in an unsecured staff break room.

This is a repeat finding.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents' care plans were not always implemented in practice, as evidenced by dressing frequency for one resident not followed in line with the resident's wound care plan.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The provider had ensured all staff had training in managing responsive behaviours. Referrals to external services such as psychiatry of later life were in place to provide a person-centred approach to care.

Judgment: Compliant

Regulation 9: Residents' rights

While the registered provider had provided facilities for occupation and recreation, they had not ensured that residents were aware of all the facilities available for their use, or were encouraged to use them. This was evidenced by:

- No residents reported using the communal areas available in the Bungalow, and some were not aware of them. The communal areas in the Bungalow were not seen to be used on the day of the inspection.
- The living/dining area on the first floor was only used by four residents during meal-times such as lunch-time and at tea-time on the day of the inspection. Inspectors saw that a staff member stored their belongings in this room, and one staff member was seen to use it for a break on the day of the inspection.
- All activities were seen to be conducted in the day/dining room on the ground floor. This meant that many different activities were taking place at the same time. For example, table top activities being carried out at the same time as three tablets were showing three different programmes, and music was playing through the speaker. This environment did not support the needs and preferences of residents who wished to spend time in a quieter area.
- Many residents spent the majority of their day in the ground floor day/dining room, with visitors confirming that this was often where they visited their loved ones.
- The outdoor area was not easily or safely accessible by residents. The threshold, pathways and sloping areas posed a falls risk, and the door was locked, with the key held by staff. This meant that residents relied on staff to access and use the area.

The registered provider had not ensured that residents could undertake personal activities in private. This was evidenced by:

- Some of the toilets had doors that were difficult to close, or were of such a size that they required the door to be open when residents were preparing to use them. Residents were seen to have the door open while arranging themselves to sit on the toilet, or to leave it open when using the toilet.
- Signage in assisted shower rooms and the bathroom instructed staff to dress residents in their bedrooms. Management confirmed this was standard practice, and residents were covered with dressing gowns when returning to their bedrooms. This did not promote the dignity of the resident.
- Despite a resident stating in a residents' meeting that the sitting room could be quite noisy, and this was observed by inspectors on the day, alternative rooms were not brought to residents' attention either during or after the meeting.
- In a twin bedroom, one resident did not have a privacy curtain to ensure their privacy and dignity.

- One twin bedroom had both wardrobes positioned in the private space of one resident, meaning that a resident could not easily access their belongings without having to enter another resident's personal space. It is acknowledged on the day of this inspection, this bedroom was not fully-occupied.

The registered provider had not always ensured that residents could exercise choice, as some residents expressed concern that they were not given full information to make an informed decision. This was evidenced by:

- Residents were not always informed that the person engaged to cut and style their hair was not a trained hairdresser. Although many residents and families spoken with were happy with the hairdressing service provided, there was no trained hairdresser available to residents when requesting this service.
- Two residents spoken with stated they were not always informed of the full contents of a consent form, and therefore had signed without full knowledge of what they were consenting to. This included a resident being charged for a service which should be covered by a medical card.

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 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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Carysfort Nursing Home OSV-000022

Inspection ID: MON-0050159

Date of inspection: 20/05/2026

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: Following the Inspection, the Registered Provider took immediate steps to address effectively all items of non-compliance or concern identified by the Inspectors during their pre-registration inspection of 20 May 2026 (the "Inspection"). These steps included the engagement at the Registered Provider's cost of a third-party professionally qualified engineer, construction/decoration contractors and fire safety experts. The Registered Provider ensured that all matters identified during the Inspection were addressed effectively in a time-bound manner before 25 June 2026. The following actions were taken: 1. Fire Safety: The Registered Provider has put enhanced fire safety measures in place. Fire exit route inspections within the Centre have increased from once daily to twice daily. These are consistently documented to ensure that all escape routes from the Centre remain clear at all times. All bedroom emergency exit consent forms were reviewed with residents and/or their representatives. New consent forms were completed following a full explanation of the purpose of the emergency exit arrangements and residents were given the opportunity to ask questions before signing. 2. Charges: The Registered Provider conducted a comprehensive review of all financial records following the Inspection. This review has confirmed, unequivocally, that no resident of our Centre has been charged for services covered under the Medical Card Scheme 3. Residents' Meetings: As a rule, Residents' Meetings are held monthly within the Centre. Following the Inspection, the Registered Provider has put in place enhanced measures to address the Inspectors' concerns. Meeting dates are communicated verbally and displayed on noticeboards at least two days in advance to maximise resident participation. Written minutes of Residents' Meetings are maintained, actions identified,	

allocated to responsible persons and reviewed at subsequent management meetings until completed

4. Complaints: An internal follow-up, after the Inspection, was conducted to inquire into the complaints made by residents to Inspectors during the Inspection. The Person-in-Charge has ensured that all staff within the Centre were re-educated on the Centre's Complaints Policy and instructed that every concern or dissatisfaction expressed verbally or in writing by a resident or relative must be documented immediately, investigated and escalated to the Complaints Officer. The Person in Charge will continue to review the complaints log monthly to ensure all concerns are documented, investigated, actioned and closed in accordance with the Complaints Policy.

5. Refurbishment: Immediately following the pre-registration Inspection, the Registered Provider put in place a Schedule of Works with professional engineering and construction assistance to address, in a timebound manner before 25 June 2026, all matters of concern (including fire safety and refurbishment) within the Centre as identified during the Inspection. During the implementation of the Works (to include refurbishments), provision was made to protect resident rights. The Registered Provider ensured that staff and residents were made aware of the Schedule of Works. Room-specific risk assessments were completed prior to commencement of the works, including resident consultation, signage, protection of residents' belongings, infection prevention measures. The Registered Provider put enhanced systems in place to ensure the effective oversight of the implementation of the Schedule of Works to include direct daily oversight by at least one executive director of the Registered Provider of the works deliverables and overall fire safety oversight and sign-off by fire safety experts', with the required Schedule of Works completed immediately before 25 June 2026.

Going forward, where any separate refurbishments have to be done within the Centre in the ordinary course, the Registered Provider will ensure at all material times that the staff and residents of the Centre will be made aware of any proposed schedule of works and engaged fully before the commencement of same. Additionally, the Registered Provider has put enhanced measures in place to strengthen ongoing oversight within the Centre. Daily management walk-arounds have been introduced, together with strengthened monthly governance meetings, to ensure that corrective actions are monitored and any non-compliance identified is addressed promptly. Increased management review focus, since the Inspection, is put on the premises of the Centre on an ongoing basis, including bedrooms, bathrooms, toilets, communal areas and other relevant areas. All issues identified will be recorded, addressed, actioned and followed through to completion.

6. Toilet/Bathroom Facilities: Following the Inspection, the Registered Provider's Board of Directors reviewed the concerns raised by Inspectors in respect of the Centre's toilets/bathroom facilities in light of complaints raised by two residents during the Inspection. The Registered Provider conducted a comprehensive review of all bathrooms and toilets within Buildings No. 1 & No. 2 of the Centre (including those on the ground floor of Building No.1), having regard to resident profile, dependency levels and complaints received by Inspectors from two residents, during the Inspection, about not being able to use the ground floor facilities. The review included the professional measurement of all bathrooms and toilets together with the confirmation of their location

within the Centre. In two bathrooms, mechanical ventilation systems were installed. Commodes were removed from bathrooms and relocated to designated storage areas. An internal follow-up, after the Inspection, established that two residents were unable to use the facilities on the ground floor because other residents were using them at the material times.

7. An unlabelled shower sponge identified during Inspection was immediately removed and disposed of. All personal care items are labelled with the resident's name and environmental audits have been updated to include checking for correct labelling.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 11: Visits	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 11: Visits:

Following the Inspection, the Registered Provider revised the Visitors' Policy to include all designated visiting areas including the Front Sitting Room, Extension Sitting Room, Main Sitting Room, Conservatory (Building 1), Patio Area, Conservatory and Sitting Room in Building 2. The updated policy was submitted to HIQA following the inspection and approved through re-registration.

Visitor information posters have been displayed throughout the nursing home advising residents and visitors of all available visiting areas.

All inappropriate storage has been removed from Building 2's sitting room.

Residents and families are informed on admission and during residents' meetings of all available communal areas for private visits, and a written to this effect has been displayed at the front door of the Centre and in all communal areas within the Centre.

Staff are instructed and will continue to be instructed to offer alternative quiet visiting areas to Visitors and Residents whenever requested.

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Registered Provider attended to all of the following actions: Following the Inspection, the Registered Provider engaged and oversaw professional third-party construction experts to ensure that all items identified by the Inspectors during the Inspection were addressed in a timebound manner: 1. All toilet seat raisers were reviewed, and where evidence of rust was identified, they were replaced; 2. All grab rails were reviewed. Where grab rails were loose, they were all securely refitted. Grab rails which showed any sign of damaged have been replaced with new rails; 3. All wall panels in the Centre were reviewed and panel showing any damage have been repaired; 4. Tree roots creating trip hazards have been removed and uneven pathways repaired to improve safe access to the garden; 5. All stained carpets throughout the communal areas and corridors were professionally deep cleaned; 6. All garden chairs were reviewed and, where showing any form of damage (including by cigarette burns) have been replaced; and 7. All inappropriate storage items were removed from bathrooms, the gardens and the staff break room. 8. Full-length doors have been installed to promote residents' dignity and privacy. 9. The toilets, bathrooms and shower rooms have been reviewed to ensure that they are accessible and suitable for the residents using them. Residents' choices and individual needs are respected during personal care. Residents are supported to dress in the bathroom where they wish to do so. Where a Resident prefers to dress in their bedroom, staff support them to return to their bedroom to dress. This ensures that residents are supported to dress safely and comfortably while maintaining their dignity, privacy and choice. The suitability and accessibility of the toilets, bathrooms and shower rooms will continue to be monitored through the daily management walk-arounds, with any identified concerns addressed promptly and reviewed through the monthly governance process. Additionally, immediately following the pre-registration Inspection of 20 May 2026, the Registered Provider conducted a comprehensive review of all bathrooms and toilets within Buildings No. 1 & No. 2 of the Centre (including those on the ground floor of Building No.1), having regard to resident profile, dependency levels and complaints received by Inspectors from two residents, during the Inspection, about not being able to use the ground floor facilities. The review included the professional measurement of all bathrooms and toilets together with the confirmation of their location within the Centre. In two bathrooms, mechanical ventilation systems were installed. Commodes were removed from bathrooms and relocated to designated storage areas. An internal follow-up, after the Inspection, established that two residents were unable to use the facilities on the ground floor because other residents were using them at the material times. Finally, the Registered Provider and Person-in-Charge have ensured the putting in place	

of enhanced systems within the Centre to ensure that:

- (i) staff members are continuously reminded that the Centre's break-room must not storage of catering items or maintenance activities; and
- (ii) the Centre's conservatory door to the garden remains unlocked during daytime hours to facilitate residents' independent access, where appropriate.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 28: Fire precautions

Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Following the Inspection, the Registered Provider attended to the following to ensure effective compliance with Regulation 28:

Fire safety experts' were engaged to ensure the identification of fire safety risks and oversee, effectively, the completion of works within the Centre to address those risks. All staff completed additional fire safety training delivered by an external provider. The training included practical evacuation drills using ski sheets, evacuation chairs and compartment evacuation scenarios, with fire safety training to continue post 1 July 2026. Fire evacuation procedures are displayed at each nurses' station and staff have received additional instruction to reinforce their knowledge and confidence in evacuation procedures.

Two fixed ashtrays remain in place within the designated smoking area and an additional table ashtray has been provided to encourage the safe disposal of smoking materials. Smoking areas are checked and cleaned three times daily to ensure safe disposal of cigarette ends.

Fire exit route inspections have increased from once daily to twice daily and are documented to ensure all escape routes remain clear at all times.

Residents requiring mobility aids have been assessed and educated regarding safe storage to ensure escape routes remain unobstructed.

Fire safety compliance is monitored through daily, weekly and monthly fire safety audits.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Following the Inspection, the following actions were taken within the Centre to address the identified the sub-compliance identified: • The nutritional supplements identified on inspection had been recently delivered and were inadvertently left in the staff break room. They were immediately transferred to the locked medication storage area. • All staff have received further instruction regarding the receipt of pharmacy deliveries. Nursing staff are immediately informed upon delivery and all nutritional supplements and medicinal products are stored securely without delay. • The staff break room has been designated as a strict "No Storage Zone". • Medication storage audits are undertaken by the ADON/CNM to ensure continued compliance.	
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: To address the sub-compliance identified, the Person-in-Charge has taken the following actions: • Nursing staff have been reminded that wound care must always follow Tissue Viability Nurse recommendations unless reviewed and amended by the TVN or GP. • Any proposed change to dressing frequency must be supported by documented clinical assessment and updated care planning. • Wound photographs are now uploaded to EpicCare every 72 hours for all active wounds or more frequently where clinically indicated. • Weekly wound care audits are completed by the ADON/CNM to ensure dressing schedules, documentation and photographic records remain fully compliant.	

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The updated Visitors' Policy includes all communal visiting areas and residents have been informed of all available sitting rooms and conservatories through residents' meetings, noticeboards and staff communication. • All inappropriate storage has been removed from Building 2 sitting room to ensure residents have unrestricted access. • Activity programmes are now delivered across both downstairs sitting rooms, the conservatories and individual resident bedrooms according to resident preference, ensuring quieter environments are available. • Residents are encouraged to use all communal facilities and staff actively support residents to access quieter areas where desired. • Bathrooms and toilets have full-length doors and ventilation installed where required. • Privacy curtains have been fitted in the identified bedroom and wardrobes repositioned to ensure residents can independently access their belongings without entering another resident's personal space. • All the signage in the assisted shower rooms have been removed and residents are supported to dress in the bathroom following bathing where they wish to do so, thereby promoting dignity and privacy. • The garden remains accessible during daytime hours and environmental improvements have reduced trip hazards. • Our complimentary in-house hairdressing service will continue. In order to address the concern raised by Inspectors during the Inspection, the Registered Provider has corresponded with Residents and/or their representatives to advise them formally of greater choice in relation to the receipt of hairdressing services. Residents whose wish is not to avail of the Centre's complementary hairdressing service may, instead, arrange, at their own cost, private hairdressing appointments directly with external providers, to include appointments with local hairdressers to receive services outside the Centre in the normal course; or with a mobile hairdresser who may visit the Centre to provide his/her services to an individual Resident in circumstances where the Resident or his/her family representative will be responsible for paying the mobile hairdresser directly. • Exit route consent forms have been reviewed and fully explained before obtaining signatures. • Financial records have been reviewed confirming that residents are not charged for Medical Card covered services. • A daily Menu Choice Recording System has been introduced to ensure residents' meal preferences are recorded and communicated to the kitchen before each meal service. Menus are displayed in all dining areas and staff explain meal choices to residents who require support. Residents who decline the main meal options are offered suitable alternatives. The Food & Nutrition Policy has been updated to include the recording of meal choices and the procedure for offering alternative meal options. • Residents' rights are monitored through regular resident satisfaction surveys, monthly residents' meetings and governance meetings.	

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 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	25/06/2026
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	Not Compliant	Orange	25/06/2026

	the matters set out in Schedule 6.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	25/06/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	25/06/2026
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored	Substantially Compliant	Yellow	25/06/2026

	securely at the centre.			
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	25/06/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	25/06/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	25/06/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	25/06/2026