

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

Issued by the Chief Inspector

Name of designated centre:	AbbeyBreaffy Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Dublin Road (N5), Castlebar, Mayo
Type of inspection:	Unannounced
Date of inspection:	26 June 2026
Centre ID:	OSV-0000308
Fieldwork ID:	MON-0050086

About the designated centre

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

AbbeyBreaffy Nursing Home is a purpose-built facility that provides care for 55 male and female residents who require long-term care or who require short periods of care due to respite, convalescence, dementia or palliative care needs. Care is provided for people with a range of needs: low, medium, high and maximum dependency. The centre is located in a countryside setting, a short drive from the town of Castlebar, just off the N5. The atmosphere created is comfortable, and there is plenty of natural light in communal areas and in bedrooms. Bedroom accommodation consists of four double rooms and 47 single rooms, of which 50 have en-suite facilities. There are toilets, including wheelchair-accessible toilets, located at intervals around the centre and close to communal areas. There are several sitting areas where residents can spend time during the day. There were dementia-friendly features in place to support residents' orientation and memory, including signage and items of memorabilia such as displays of china and old-style equipment. An accessible and safe courtyard garden, centrally located, has been well-maintained to provide interest for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52
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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
Friday 26 June 2026	07:00hrs to 14:35hrs	Michael Dunne	Lead
Friday 26 June 2026	07:00hrs to 14:35hrs	Helena Budzicz	Support

What residents told us and what inspectors observed

Overall, the findings of this inspection demonstrated that residents were satisfied with the care and services provided in the centre. Residents provided positive feedback regarding their quality of life and overall experience of living in the centre. Residents told the inspectors that they felt safe, were well cared for, and enjoyed the food provided. One resident commented, "This is a wonderful place; I love it here," while another stated, "I have no complaints whatsoever." Inspectors also spoke with visitors attending the centre, who expressed high levels of satisfaction with the care provided. Visitors described the care as excellent, and confirmed that there was regular communication from the centre regarding the health and wellbeing of their loved ones.

This inspection was a one-day unannounced inspection conducted by two inspectors to monitor compliance with the regulations. The inspectors arrived at the designated centre at 7:00 am, and were welcomed by night-duty staff. Prior to the arrival of the management team, the inspectors conducted an initial walk around the centre, during which they met, and spoke with residents, and staff members. Shortly afterwards, the inspectors met with the assistant director of nursing (ADON), followed by the person in charge. Following a request for documentation to support the inspection process, the inspectors continued their walk around of the centre.

An introductory meeting was held with the person in charge. This included a review of the provider's compliance plan arising from the previous inspection conducted in September 2025. The inspectors also provided feedback on their initial observations, and findings from the walk-around of the designated centre.

Residents who spoke with inspectors expressed satisfaction with the care and support provided by staff. They described staff as helpful, committed, and responsive to their needs. Residents confirmed that they felt safe living in the centre, and were comfortable raising any concerns with members of the staff team. Inspectors observed positive and respectful interactions between staff and residents, including those with communication support needs. Residents were given appropriate time and encouragement to express their views. These interactions demonstrated that staff had a good understanding of residents' individual needs, and responded to them effectively. Residents who walked with purpose were supported in a dignified and respectful manner. This approach was observed to reduce the risk of distress and promote the safety and well-being of those residents.

Residents had access to a variety of communal areas, including a spacious reception area, two sitting rooms, a visitors' room, a family room, and an oratory. The dining room was bright, spacious, and provided ample seating for residents. During the inspection, the inspector observed that residents spent most of their day in one of

the two sitting rooms or in the reception area. Residents with higher support needs were primarily observed spending their time in the Summerbrook sitting room.

The centre's corridors were long and wide, providing adequate space for residents to walk safely and comfortably. Handrails were installed throughout the corridors, supporting residents' safety, mobility, and independence. There was unrestricted access to a large communal garden. The garden was attractively landscaped with flowers and shrubs, and contained sufficient seating areas for residents to relax and enjoy the outdoor environment.

Overall, the inspectors found the centre was suitable to meet the needs of the current residents. For the most part, it was odour-free apart from an unclean cushion in one of the communal rooms. There was ongoing maintenance support in place to maintain the fabric of the building. Inspectors noted a degree of wear-and-tear in flooring in some parts of the centre, and in the jambs of doors, which was highlighted in previous inspection reports. During the walk around of the building, the inspectors noted that there were gaps around some compartment fire doors, and one fire door in particular did not close properly. This was pointed out to the provider on the day, who rectified this issue.

Resident rooms were tastefully decorated with personal items, pictures, and flowers. Residents' rooms were spacious, and provided sufficient storage space for residents to be able to store, and retrieve their personal belongings. All rooms were also observed to contain televisions, chairs, and lockable storage units.

Overall, the food service was well-managed, with dedicated staff available to support residents with eating and drinking as required. Residents were observed attending the dining room throughout the morning, while others were supported to have breakfast in the privacy of their bedrooms. Pictorial menus were displayed on notice boards, clearly outlining the meal choices available for the day, including beef stroganoff and a cod mornay option. Tea time options were also displayed, and included sausage and chips, a selection of sandwiches, yogurts, cakes, and biscuits.

Inspectors observed the lunchtime service in both the main dining room and the multi-purpose room. The main dining room was well-organised, and comfortably arranged to promote a pleasant dining experience for residents. Staff demonstrated a good knowledge of residents' dietary preferences and choices, and inspectors observed positive and effective communication between staff and residents throughout the meal service. However, the dining experience in the second dining room was not consistently person-centred. Residents had limited opportunities for choice and decision-making, as meals were pre-plated prior to service. This practice reduced residents' ability to change their pre-selected meal option at the point of service.

Inspectors observed residents participating in both group activities and individual routines. A varied weekly activity programme was in place. On the day of inspection, some residents took part in board games, while others were supported to engage in arts and crafts. Additional activities included a music session and a ball toss game.

Communal areas were well-equipped to support resident participation, with appropriate resources available for music, arts, and crafts activities.

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

Capacity and capability

Overall, the inspectors found that this was a well-managed centre where the residents were supported and facilitated to have a good quality of life. The majority of systems in place ensured that care, and support services were safe and provided in line with the designated centre's statement of purpose. Notwithstanding the good levels of oversight, additional focus was required to ensure that all systems in place were effective in monitoring the delivery of care to residents and ensuring that residents had a care plan in place to meet their care needs. The issues concerned are discussed in greater detail under the relevant regulations.

This unannounced inspection was carried out by inspectors of social services to monitor the registered provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended), and to follow up on the provider's compliance plan commitments arising from the inspection carried out in September 2025. The findings of this inspection are that the registered provider had carried out a number of actions in order to achieve compliance with the regulations. However, works carried out by the provider to upgrade fire safety in the designated centre were not sufficient, as identified in their Fire Safety Risk Assessment (FSRA) report in April 2026. At the time of this inspection, the provider was carrying out the outstanding fire safety works, which were overseen by the competent person, with an expected completion date of September 2026.

The designated centre is operated by Knegare Nursing Home Holdings Limited, and is the registered provider for AbbeyBreaffy Nursing Home, and part of Brookhaven Healthcare Group operating a number of nursing homes in Ireland. There was a clearly defined management structure in place that identified roles and responsibilities within the designated centre. The person in charge was supported by an assistant director of nursing (ADON), a clinical nurse manager (CNM), staff nurses, health care assistants, activity staff, household, and maintenance staff.

A restrictive condition was added to the centre's registration renewal in December 2025, preventing admissions to a twin-occupancy bedroom that is currently occupied by a single resident. This restriction was imposed due to the room's layout, which would not adequately support residents' privacy and dignity if occupied by two individuals. The provider has committed to maintaining single occupancy of this

room. Accordingly, the centre's registration was renewed in December 2025 subject to this restrictive condition.

The provider maintained regular oversight of the centre through ongoing review and analysis of information gathered to improve outcomes for residents. Inspectors found that, for the most part, there were effective systems in place to oversee record management. The availability of accurate and up-to-date information ensured the delivery of suitable and effective services for residents. A range of clinical audits, including medication management, wound care, and care planning, were completed to assess internal practices. Where areas for improvement were identified, action plans were developed and implemented. There were some areas of the service that required additional focus, and these are discussed in greater detail under Regulation 23: Governance and management.

Regular meetings were held between the local management team and the provider to review key oversight indicators relating to the governance and management of the designated centre. A review of meeting records demonstrated appropriate scrutiny of key areas of the service, including resident care, complaints, risk management, staffing, catering, and maintenance of the premises.

A comprehensive review of the service was completed by the provider for 2025. The annual review focused on key areas of quality and safety, and was informed by feedback gathered through resident surveys and resident meetings. The review identified areas for ongoing development, and a Quality Improvement Plan for 2026 was developed. At the time of inspection, the provider was progressing actions outlined within this plan.

There were effective arrangements in place to identify, assess, and manage risk, ensuring residents were protected from the risk of harm. A risk management policy and procedure updated in February 2026 was available to guide staff in the management of risk within the centre. A comprehensive risk register was maintained, reviewed on a regular basis, and updated as required. This live document included both clinical and environmental risks, with appropriate control measures in place. Risks were effectively monitored, mitigated, and escalated through the relevant governance structures when necessary.

There were sufficient numbers of staff available in the designated centre throughout the inspection to meet the assessed needs of residents. Arrangements were also in place to maintain staffing levels, and ensure adequate cover for staff absences. A review of staff rosters confirmed that all absences had been appropriately covered by the provider. On the day of the inspection, the staffing complement consisted of two staff nurses and eight health care assistants, providing appropriate support to residents. Staff resources at night consisted of two staff nurses and three health care assistants. On the day of this inspection, there were 52 residents living in the designated centre.

Staff reported that they had access to regular training, and demonstrated a good knowledge of key areas of safe working practice, including fire evacuation procedures, and infection prevention and control standards.

A complaints policy was in place and had been updated in line with legislative changes and the additional requirements of Regulation 34. A designated complaints officer, and review officer had been identified. All complaints, and feedback were appropriately recorded, reviewed, and communicated to the relevant staff to support learning, and service improvement. There was one open complaint the provider was managing in line with their complaints policy. Three complaints had been received so far for 2026, with all closed out to the satisfaction of the complainant.

Regulation 15: Staffing

There were adequate numbers of staff with appropriate skills available to meet residents' assessed care and support needs. Staff were knowledgeable regarding residents' individual needs and assisted residents with meeting their needs without delay. A review of the rosters confirmed that staff numbers were consistent with those set out in the centre's statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed by the inspectors in the centre confirmed that staff had completed a selection of online and in-house training activities. All staff had completed their mandatory training in moving and handling, fire safety, safeguarding training and transmission-based precautions training.

Judgment: Compliant

Regulation 21: Records

The registered provider ensured that records set out under the Schedules of the regulations were maintained in the centre and were available for review. All records reviewed were maintained in a safe and secure manner.

Judgment: Compliant

Regulation 23: Governance and management

The inspectors found that the registered provider had management systems in place to monitor the quality of the service provided; however, some actions were required to ensure these systems were sufficient to ensure all aspects of the service provided were safe, appropriate, and consistent. For example:

- Notwithstanding the actions taken to date, there were significant delays in ensuring that fire safety works were completed to the required standards.
- The oversight of the dining experience was not sufficient to ensure all residents in all units enjoyed a dining experience that upheld their rights and dignity.
- Environmental audits were not sufficiently robust and had not identified areas of the centre that required repair.
- Care plan audits had not identified key areas for improvement and gaps in the care planning arrangements, including, for example, the support interventions to guide staff in the care of a resident with known high levels of anxiety.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A Statement of Purpose (SOP) updated in May 2026 was available at the designated centre. The document clearly outlined the centre's vision, mission, and values, and accurately described the facilities and services provided to residents, as well as the size and layout of the premises.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of incident and accident records confirmed that two-day notifications were submitted to the office of the Chief Inspector of Social Services within the required timeframe. Inspectors reviewed a sample of residents' care records and documentation relating to the use of restrictive practices in the designated centre. The records demonstrated that the provider was submitting quarterly reports in accordance with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had an effective complaints procedure in place that clearly outlined the process for making and reviewing complaints. The complaints policy was available to residents and their representatives and was referenced in both the Statement of Purpose and the Residents' Guide.

The complaints officer and review officer were clearly identified, with contact details provided. The policy also included information on advocacy services to support residents in making a complaint or where they felt their concerns had not been adequately addressed.

A review of the complaints log found that both formal and informal complaints were recorded and managed in accordance with the centre's complaints policy.

Judgment: Compliant

Quality and safety

Overall, during the inspection, staff were observed working collaboratively for the most part to ensure that residents' needs were met in a timely and person-centred manner. This contributed to a positive, caring, and supportive environment, where residents informed the inspector that they felt valued, respected, and well cared for. Care was delivered in an open, supportive, and respectful manner, with residents' rights upheld, albeit some further areas for improvement were identified in respect of the meal service, as detailed in this report.

Residents experienced flexible daily routines and were supported to spend their day according to their preferences, choosing whether and how to participate in activities and daily routines. Staff demonstrated good knowledge of residents and their individual preferences, regularly offering choices and encouraging opportunities to enhance their well-being. Residents were supported to make their own decisions, and any refusal of care or services was respected.

For the most part, care plans were person-centred, effectively implemented, regularly evaluated, and reviewed. They reflected residents' evolving needs, and clearly outlined the supports required to maximise their quality of life in line with their wishes and preferences. However, a review of care plans also found that some care plans needed to be streamlined so that care interventions were clear and easy to follow. This is further described under Regulation 5: Individual assessment and care plan.

Residents had good access to their general practitioner (GP), and specialist medical services including psychiatry of old age. Specialist health services such as dietitian, speech and language therapy, tissue viability nurses, palliative care and occupational therapy, and physiotherapy services were made available for residents in line with

their needs. A review of transfer records confirmed that the provider included key information for residents who were transferred to acute centres.

Staff and resident interactions that were observed by the inspectors were found to be supportive and positive. The provider maintained good levels of communication with residents, ensuring they were kept up-to-date regarding key events in the home. Resident meetings were informative and covered topics such as resident care, food and catering, resident activities and infection prevention and control issues. In addition to the structured resident meetings, the provider kept residents informed either verbally or through regular written communication. Residents' rights to privacy and dignity were respected; staff were observed to knock on residents' doors prior to entry and explained to the residents the purpose of their visit.

There were opportunities for residents to engage in the activity programme in line with their interests and capabilities. Residents were seen to engage in planned activities throughout the day while other residents pursued their own individual interests either in communal areas or in their own room. Residents had access to television, radio and newspapers. Advocacy services were made available for residents, and information about the services was available on the notice boards.

The provider had carried out significant fire safety improvement works across the centre. Compartmentation cross-corridor doors had been fitted to reduce the size of existing compartment areas, fire stopping had been completed in the attic areas, works to external evacuation paths and emergency lighting had been carried out, internal emergency directional signage had been fitted throughout and remedial works to a number of fire door sets were in progress. Following an updated fire safety risk assessment (FSRA), the competent person found that additional works were required to the completed works as some upgrades did not meet the required fire safety standards. The additional works that were required are discussed further under Regulation 28: Fire Precautions.

The provider informed the inspectors that 45% of the works identified in the FSRA had been carried out with an estimated completion date of September 2026. A review of fire safety records found that comprehensive systems were in place to monitor fire safety within the designated centre. Staff demonstrated a clear understanding of the fire procedure, and were able to outline the actions required in the event of a fire emergency. Records confirmed that regular fire drills and simulated evacuations were conducted as part of the provider's fire safety arrangements. Personal Emergency Evacuation Plans (PEEPs) were also in place to guide staff in meeting the individual evacuation needs of residents.

Residents' nutritional needs and risks were appropriately assessed and monitored. Where required, residents were referred to dietetic and speech and language therapy services, and recommendations informed the development of person-centred nutritional care plans. These plans were communicated to relevant care and catering staff. Residents' nutritional status was monitored through regular weight checks, with more frequent reviews undertaken where indicated.

A review of medicines management and pharmaceutical services in the centre found that they were well-managed, with appropriate systems in place to support the safe storage, administration, and oversight of medications.

Regulation 11: Visits

There were no visiting restrictions in place at the time of inspection. Visitors were observed coming and going throughout the day, and those spoken with confirmed that visiting was encouraged and facilitated by the centre.

Judgment: Compliant

Regulation 17: Premises

A review of the premises found that some areas were not maintained in line with the requirements of Schedule 6. For example:

- Wall surfaces and door jambs were scuffed and in run-down condition in some areas of the centre, making these areas difficult to clean.
- Flooring was damaged in some areas of the centre, and this meant it could not be cleaned properly.
- A strong malodour was noted from the seat cushions in the sitting room, indicating a need for improved cleaning and maintenance.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The dining experience was not consistent for all residents. For example, inspectors observed a dining room serving 11 high-dependency residents, in which the environment did not meet the standards seen elsewhere in the centre. Although tables were set with tablecloths, menus and condiments, items such as sauces, butter, salt and pepper were not readily accessible. Cutlery was placed directly on tables without napkins, and as meals were pre-plated, residents were not offered a choice of additional sauces. Overall, these arrangements did not promote a positive dining experience.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Transfer letters reviewed during the inspection contained all relevant resident information, demonstrating effective communication between services and supporting continuity of care. Hospital discharge letters were also retained in the resident's file.

Judgment: Compliant

Regulation 26: Risk management

The provider had implemented a comprehensive risk management policy and maintained a risk register in line with regulatory requirements.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the regulatory requirements and the National Standards for Infection Prevention and Control in Community Services (2018). There were some areas of the premises that required upgrades, as further deterioration could have a negative impact on effective infection control protocols. This is described in more detail under Regulation 17: Premises.

Judgment: Compliant

Regulation 28: Fire precautions

Although the provider had carried out a programme of fire safety upgrades, a review by their competent person found that these works were not sufficient and did not provide the required levels of protection. Further action was required in respect of fire containment measures, compartmentation and emergency lighting. For example:

- Confirmation was required that existing corridor ceilings provide the required levels of protection.
- A large number of existing fire doors that provide 30-minute protection lacked cold smoke seals.

- Gaps were identified around several fire door sets, compromising their ability to prevent the spread of fire and smoke throughout the centre.
- A number of fire doors failed to close when the door closer mechanism was released.
- There was no certification in place to confirm that material used for fire stopping met the required specifications.
- There were a number of fire stopping breaches identified where ventilation diffusers, air valves, ceiling speakers, cables, and pipes punctured fire-rated ceilings and compartment lines.
- There was a lack of certification or fire rating tags to prove that ceiling access hatches maintained the integrity of a 30-minute fire barrier.
- The attic fire compartmentation is compromised by gaps, inadequate fire-stopping materials, unprotected service penetrations, and breaches caused by timber boardwalks, requiring remedial works to restore the intended level of fire resistance and evacuation safety.
- The high-hazard boiler room ceiling contained gaps with white mastic around pipe penetrations, with no visible fire-stopping identification tags to verify the required 60-minute fire-resistance rating.
- Hydrants are not located at a distance away from the building as conditioned in the fire safety certificate.
- Some emergency lights and directional signage were identified as not working or missing.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Arrangements were in place for the segregation and disposal of medicinal products that were out-of-date or no longer required. There were current policies in place regarding the ordering, receipt, storage, and administration of medicines for residents. Records showed that controlled drug balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessments and care plans found some gaps, and noted that they did not consistently meet regulatory requirements. For example:

- Some care plans contained outdated dietetic recommendations, including entries dating from 2024, which may lead to confusion in the delivery of care.

- Following an incident involving a resident displaying repetitive distress, there was no behavioural support care plan or safeguarding care plan in place to guide staff in responding appropriately.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate medical, health, and social care support to meet their needs. Residents had timely access to their general practitioners (GPs) and specialist services such as tissue viability and physiotherapy as required. Residents also had access to other health and social care professionals such as speech and language therapy, a dietitian, a tissue viability nurse, a psychiatrist of old age, and chiropody.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff demonstrated appropriate knowledge and skills in responding to and managing behaviours of concern. Restrictive practices were implemented in line with national policy. At the time of this inspection, there were no bedrails in use within the designated centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents who spoke with the inspectors reported feeling safe in the centre and stated that their rights, privacy, and preferences were respected. They were supported to attend religious services and access independent advocacy services where required. Residents also had opportunities to participate in meaningful daily activities, with a number of summer outings planned.

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 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for AbbeyBreaffy Nursing Home OSV-0000308

Inspection ID: MON-0050086

Date of inspection: 26/06/2026

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Fire Safety: • Please see full detailed response under Regulation 28 for all aspects relating to fire safety. Dining Experience • Continue with menu choices being taken from residents prior to mealtimes, assisting the chef to prepare and plate modified diets appropriately and presentably according to residents' individual needs and preferences. PiC/ ADON/ CNM. Completed and ongoing. • Standardise the dining environment across all units, including the high-dependency area. PiC/ ADON. Completed and ongoing. • Residents in the high-dependency area will have their dining tables set up in advance, with napkins, appropriate cutlery, sauces, butter, salt, pepper and other suitable condiments readily available. PiC/ ADON. Completed and ongoing. • Ensure residents are offered choice of appropriate accompaniments with their meals. ADON/ CNM. Completed and ongoing. • Ensure residents' choice, dignity, independence and preferences are maintained during mealtimes. PIC/ ADON/ CNM. Completed and ongoing. • Provide staff with guidance on person-centred dining and residents' rights. PiC/ ADON. Completed by 30/09/2026. • Conduct regular mealtime observations and dining audits across all units. PiC/ ADON/ CNM. Completed and ongoing. • Obtain residents' feedback during residents committee meeting. Address any concerns identified. PiC/ ADON. Completed and ongoing. • Management will review audit findings and ensure corrective actions are implemented and monitored. PiC/ ADON. Completed and ongoing. Environmental Audits: • Completed a full environmental inspection of the centre to identify all areas requiring	

repair, refurbishment or improved cleaning. Facilities Manager. Completed and ongoing.

- Repair and redecorate scuffed and damaged wall surfaces and door jambs to ensure they are maintained in a good, cleanable condition. This will be completed by the facilities team on a planned programme of upgrades. Ongoing.
- A flooring audit has been completed to identify all areas requiring repair or replacement. A schedule is in place to replace damaged flooring on a priority basis, taking account of resident safety, condition of the flooring and availability of bedroom vacancies. Facilities Manager/ RPR. Completed and ongoing.
- A system has been implemented for the cleaning and maintenance of seat cushions, including cleaning at nighttime where required, to ensure appropriate cleaning practices are consistently followed. PiC/ ADON/CNM. Completed and ongoing.
- Cleaning and environmental standards will be regularly monitored by management, with follow-up audits completed to ensure the required standards are maintained. PiC/ADON. Completed and ongoing.
- Cleaning and maintenance standards will be monitored through regular audits, with follow-up checks to ensure improvements are maintained. PiC/ADON/ Support Service Manager. Completed and ongoing.

Individual Assessment and Care Plan

- Complete a comprehensive review of all residents' assessments and care plans to ensure they reflect their current needs and meet regulatory requirements. PiC/ ADON. Ongoing.
- Review all dietetic, nutritional, clinical and other professional recommendations and remove or update any outdated information, ensuring current recommendations are clearly documented and followed. CNM/ ADON. Completed and ongoing.
- Nursing staff will ensure that care plans are reviewed and updated following any change in a resident's condition, needs, risks or professional recommendations. Completed and ongoing.
- Following any incident involving distress, repetitive behaviours, changes in behaviour or safeguarding concerns, the resident's assessment and care plan will be reviewed promptly. ADON/ PiC. Completed and ongoing
- Where required, develop an individualised behavioural support care plan and/or safeguarding care plan to provide clear guidance to staff on how to respond appropriately and consistently. ADON/ Staff Nurse allocated.
- Ensure care plans clearly identify triggers, signs of distress, appropriate interventions, preventative measures and escalation procedures, where relevant. Staff Nurse Allocated/ ADON/ CNM. Completed
- Staff will be informed of any significant changes to residents' care plans and provided with appropriate guidance and supervision to ensure interventions are consistently implemented. ADON/ CNM. Ongoing
- Complete regular care plan audits to identify gaps, outdated information and areas requiring improvement. ADON/ CNM. Completed and ongoing.
- All identified gaps will be recorded, assigned to a responsible person and addressed within an agreed timeframe. ADON/ CNM. Completed and ongoing.
- Management will complete follow-up audits to confirm that care plans have been updated and that improvements have been implemented and sustained. ADON/ CNM. Completed and ongoing.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Completed a full environmental inspection of the centre to identify all areas requiring repair, refurbishment or improved cleaning. Facilities Manager/ RPR. Completed and ongoing. • Repair and redecorate scuffed and damaged wall surfaces and door jambs to ensure they are maintained in a good, cleanable condition. Facilities Team/RPR. Ongoing. • A flooring audit has been completed to identify all areas requiring repair or replacement. A schedule is in place to replace damaged flooring on a priority basis, taking account of resident safety, condition of the flooring and availability of bedroom vacancies. Facilities Manager/ RPR. Completed and ongoing. • A system has been implemented for the cleaning and maintenance of seat cushions, including cleaning at nighttime where required, to ensure appropriate cleaning practices are consistently followed. PiC/ ADON/CNM. Completed and ongoing. • Cleaning and environmental standards will be regularly monitored by management, with follow-up audits completed to ensure the required standards are maintained. PiC/ADON. Completed and ongoing. • Cleaning and maintenance standards will be monitored through regular audits, with follow-up checks to ensure improvements are maintained. PiC/ADON/ Support Service Manager. Completed and ongoing.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: • Continue with menu choices being taken from residents prior to mealtimes, assisting the chef to prepare and plate modified diets appropriately and presentably according to residents individual needs and preferences. PIC/ADON/CNM. Completed and Ongoing. • Standardize the dinning environment across all units, including the high-dependency area. PIC/ADON. Completed and ongoing. • Residents in the high-dependency area will have their dinning tables set up in advance, with napkins, appropriate cutlery, sauces, butter, salt, pepper and other suitable condiments readily available. PIC/ADON. Complete and ongoing. • Ensure residents re offered choice of appropriate accompaniments with their meals. ADON/CNM. Completed and ongoing. • Ensure residents choice, dignity, independence and preferences are maintained during	

mealtimes. PIC/ADON/CNM. Completed and ongoing.

- Provide staff with guidance on person-centered dining and residents rights. PIC/ADON. Completed by 30/09/2026.
- Conduct regular mealtime observations and dining audits across all units. PIC/ADON/CNM. Completed and ongoing.
- Obtain residents feedback during Residents Committee meeting. Address any concerns identified. PIC/ADON. Completed and ongoing.
- Management will review audit findings and ensure corrective actions are implemented and monitored. PIC/ADON. Completed and ongoing.

Regulation 28: Fire precautions

Not Compliant

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

- The fire protection provided by the existing corridor ceilings will be reviewed by the Centre's Fire Safety Consultant, who will liaise with the local authority to confirm that the required level of protection is in place and acceptable.
- Cold smoke seals have now been installed on all existing 30-minute fire doors.
- All gaps identified around fire door sets are being addressed. Thirty-two door sets have been resolved, with four remaining. This work will be completed by 20th September.
- All fire doors have been reviewed, and every door closer mechanism now releases and closes the door correctly.
- Certification confirming that the fire-stopping materials used meet the required specifications will be provided by the contractors as part of the final sign-off on the overall fire safety works at the Centre.
- Remedial works to resolve all fire-stopping breaches where ventilation diffusers, air valves, ceiling speakers, cables and pipes penetrate fire-rated ceilings and compartment lines are scheduled, with a completion date of 30 September.
- All ceiling access hatches have been replaced, and certification confirming that they maintain the integrity of the 30-minute fire barrier will be sought.
- Remedial works to restore the attic fire compartmentation, including sealing gaps, replacing inadequate fire-stopping materials, protecting service penetrations and addressing breaches caused by timber boardwalks, are scheduled for completion by 30 September.
- The location of the hydrants relative to the building, as conditioned in the fire safety certificate, is currently under review with the Centre's Fire Safety Consultant.
- All emergency lights and directional signage have been reviewed, and any that were missing or not working have been replaced or repaired. All are now in working order. Completed works will be verified and all relevant documentation/certification retained.

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: • Complete a comprehensive review of all residents' assessments and care plans to ensure they reflect their current needs and meet regulatory requirements. PiC/ ADON. Ongoing. • Review all dietetic, nutritional, clinical and other professional recommendations and remove or update any outdated information, ensuring current recommendations are clearly documented and followed. CNM/ ADON. Completed and ongoing. • Nursing staff will ensure that care plans are reviewed and updated following any change in a resident's condition, needs, risks or professional recommendations. Completed and ongoing. • Following any incident involving distress, repetitive behaviours, changes in behaviour or safeguarding concerns, the resident's assessment and care plan will be reviewed promptly. ADON/ PiC. Completed and ongoing • Where required, develop an individualised behavioural support care plan and/or safeguarding care plan to provide clear guidance to staff on how to respond appropriately and consistently. ADON/ Staff Nurse allocated. • Ensure care plans clearly identify triggers, signs of distress, appropriate interventions, preventative measures and escalation procedures, where relevant. Staff Nurse Allocated/ ADON/ CNM. Completed • Staff will be informed of any significant changes to residents' care plans and provided with appropriate guidance and supervision to ensure interventions are consistently implemented. ADON/ CNM. Ongoing • Complete regular care plan audits to identify gaps, outdated information and areas requiring improvement. ADON/ CNM. Completed and ongoing. • All identified gaps will be recorded, assigned to a responsible person and addressed within an agreed timeframe. ADON/ CNM. Completed and ongoing. • Management will complete follow-up audits to confirm that care plans have been updated and that improvements have been implemented and sustained. ADON/ CNM. Completed and ongoing. • Ongoing Weekly Status Calls with Senior Management teams where Clinical KPI's are reviewed and oversight provided.	

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(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	15/12/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	30/09/2026
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.	Substantially Compliant	Yellow	30/09/2026
Regulation 28(1)(b)	The registered provider shall provide adequate	Not Compliant	Orange	30/09/2026

	means of escape, including emergency lighting.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/09/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/09/2026
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	30/09/2026