



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

Issued by the Chief Inspector

Name of designated centre:	Rosemount House Nursing Home
Name of provider:	Rosemount Nursing Home Limited
Address of centre:	Garrabeg Road, Church Street, Gort, Galway
Type of inspection:	Unannounced
Date of inspection:	04 June 2026
Centre ID:	OSV-0004583
Fieldwork ID:	MON-0050641

About the designated centre

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

Rosemount House provides 24 hour nursing home care for adults ranging in age from 18 to 65 and older, both male and female, in a comfortable, relaxed and homely environment. Residents who require convalescent, respite, short and long term care with low, medium, high and maximum dependencies can be accommodated. The facilities include the single storey purpose-built nursing home and secure garden/courtyards.

The centre provides accommodation for 40 residents in single and twin bedrooms, a number of which are ensuite.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36
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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
Thursday 4 June 2026	09:30hrs to 17:35hrs	Sharon Kane	Lead
Thursday 4 June 2026	09:30hrs to 17:35hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Overall, residents reported feeling happy and safe living in the centre. Care observed during the inspection appeared to be of satisfactory quality. However, inspectors observed that minimal action had been taken to address issues relating to flooring and the general upkeep of the centre since the last inspection.

Rosemount House Nursing Home is a single-storey facility located in Gort, County Galway. It was registered to accommodate up to 40 residents and comprised single and twin bedrooms, along with communal areas including two day rooms, a dining room, and a sun room.

On arrival to the centre inspectors were greeted by the person in charge, and following a brief introductory meeting, the inspectors had a walk through the centre. This gave the inspectors an opportunity to observe the environment and meet with residents and staff. Residents were observed receiving their breakfast in the dining room, day room or their bedrooms. Other residents were observed spending time in the main day room and receiving care in their bedroom.

An inspection in February 2026 had identified significant issues within the premises. This inspection found repeated maintenance issues, including the flooring in all areas through the centre, that had not been addressed by the provider. Flooring was significantly damaged in some areas of the centre and posed a trip hazard to residents and attendees to the centre. Wall surfaces in residents' bedrooms and communal areas were scuffed. Some residents' furniture was observed to be in a poor state of repair, including beds and chairs. The call bell system had been recently upgraded, however, call bells were not available in all rooms used by residents. There was no privacy screen available in some shared bedrooms. The outside space, available for use by residents, was poorly maintained. Some moss was noted to paths and parts of the roof was covered in moss.

Fire safety concerns were observed by inspectors. For example, a fire door into the day room was stuck to the floor and was unable to be closed, door closers were alarming, and another fire door into the day room was held open with a table. The smoking room, located off the day room, did not have adequate ventilation and there was no fire extinguisher in the room. At times during the inspection, residents were observed being seated in front of a fire exit door in the day room, impeding the route should evacuation be required.

The previous inspection of the centre had found very poor practice in relation to the safe and effective nutritional support for residents. This inspection found some improvement in the dining experience of residents. There were menus displayed in the dining room and a choice of main meal was offered daily. Since the last inspection, the provider had placed a dining table in the front day room to facilitate residents to attend a dining area for meals, however, the area was in a poor state of

repair, and was not appealing as a dining space. There were no residents dining in this area on the day of the inspection. Some residents were observed attending the dining room for meals, and meals appeared to be wholesome and nutritious. Residents reported that the food was of good quality and that they had enjoyed their meal. A large number of residents continued to have meals delivered to them on trays in the centre's main day room or in their bedrooms. Inspectors observed that the supervision of the residents who were served their meal in their bedroom was not effective. One resident, who was served their meal in their bedroom, was observed to dispose of their meal without this being identified by staff.

While communal areas were supervised by staff through the inspection, several residents were observed to spend the day in bed, or in their bedroom.

Staff and resident interactions were observed to be kind and patient. It was evident that residents' likes and interests were known to staff. Residents spoken with described the staff as friendly and caring. A resident who inspectors had spoken with on the last inspection, advised that they felt that things had improved in the last few months with regard to the waiting time for care. Residents reported that they enjoyed the food and that there was tea and snacks on offer through the day. Residents described how they could choose how to spend their day. A resident described that they liked to get up early to have their breakfast and that the breakfast was always delivered to them as soon as they requested it.

Religious prayer was facilitated daily. A musician attended the centre in the afternoon and played music in the day room. Residents reported that there was plenty of things to do in the centre and that they had things to keep them busy, however, there was no activity schedule in place. This meant that the residents did not know what activity would be available to them on a day-to-day or weekly basis.

Visitors spoken with were satisfied with the care their family member received. They stated that the staff and management were kind and approachable, and they felt that their family member were well-supported in the centre.

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

Capacity and capability

This unannounced inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). This inspection was scheduled to follow up on the action taken by the provider following significant non-compliance found on inspection of the centre in February 2026. Inspectors also

reviewed notifications that had been submitted to the Chief Inspector by the provider since the previous inspection in February 2026.

Following the February inspection, an urgent compliance plan was issued to the provider to address the issues of highest risk in relation to governance and management, fire precautions and food and nutrition. In March 2026, a warning meeting was held with the provider outlining the action that the Chief Inspector would take, namely, to cease admissions to the centre, if the registered provider failed to come into compliance with the regulations. At this meeting, the registered provider told the Chief Inspector that a decision had been made by the provider to cease admissions to the centre until compliance with the regulations had improved. This inspection found that six residents had been admitted to the centre since the last inspection.

The findings of this inspection identified significant and repeated non-compliance in the governance and management of the centre. Additionally, the provider had not fully implemented the actions committed to in the compliance plan submitted to the Chief Inspector following the inspection carried out in March 2026. This inspection found that there was continued significant non-compliance in relation to Regulation 23: Governance and management, Regulation 17: Premises, and Regulation 28: Fire Precautions.

Rosemount Nursing Home Limited is the registered provider of the centre. The registered provider is a company that comprises of four directors. The registered provider is represented in communications with the Chief Inspector by one director. The management structure in the centre consisted of a general manager, the person in charge and a newly appointed clinical nurse manager. The staffing complement was made up of a team of nurses, health care assistants, cleaning, laundry and catering staff.

This inspection found that the organisation structure in the centre was not effective. There was unclear delegation of roles and responsibilities. It was unclear how issues of risk and concern were escalated to the registered provider, and by whom this action was taken. While there was one governance and management meeting recorded between the representative of the registered provider, the person participating in management and the person in charge, since the last inspection, there was no record of any other communication between the management team. It was not clear who held responsibility to identify or address risks in the centre. All clinical decisions and oversight was the responsibility of the person in charge. There was no clinical support available to the person in charge within the centre, and a limited external pathway to escalate issues of clinical concern.

The management systems in place to oversee the centre were not effective. The provider had failed to put appropriate and effective systems in place to ensure that the service was safe and effectively monitored. For example, the provider had committed to completing a full audit of staff personnel files following the last inspection. However, this had not been completed and some files reviewed did not contain the required information. Some clinical and environmental audits had been

completed since the last inspection, identifying issues of risk, however, no action plan had been developed to address the identified risks.

Staffing numbers and skill mix on the day of the inspection were appropriate to meet the needs of the residents. A review of the rosters identified that an additional staff member had been assigned to night duty since the previous inspection and that a further 8am-3pm, health care assistant shift, had been added to the roster. This was found to have a positive impact on the the deliver of care in a timely manner.

Inspectors reviewed the training records of staff to ensure that training was appropriate and up-to-date. The provider had committed to ensuring that all staff would attend fire safety and manual handling training following the findings of the last inspection. This inspection found that staff had not commenced training in fire safety. In addition, some staff did not have up-to-date manual handling training.

This inspection found that care delivery was poorly supervised. Poor fire safety practices, such as fire doors wedged open, and blocked fire escapes were observed by inspectors. In addition, there was an inadequate system in place to supervise staff delivering meals to residents.

Record management systems consisted of both an electronic and a paper-based system. While some action had been taken to organise the paper-based system of record keeping, some records reviewed were not maintained in line with the regulatory requirements. For example, a review of staff personnel files found that not all files were maintained in accordance with the requirements of Schedule 2 of the regulations.

Regulation 15: Staffing

The number and skill mix of staff was appropriate with regard to the needs of the residents, and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of staff training found that staff had not attended appropriate training, commensurate to their role, and committed to by the registered provider following the last inspection. This was evidenced by;

- Staff had not attended up-to-date fire training.
- Some staff had not completed up-to-date manual handling training.

The supervision of staff practices was not always effective. This was evidenced by:

- poor oversight of fire safety precautions. For example, a door was wedged open inappropriately, a table was left in front of another door, and a door to the day room was unable to be closed.
- inadequate supervision and oversight of staff delivering nutritional care to residents. For example, there was no staff allocated to the supervision of residents who eat their meals in their bedroom
- poor oversight and supervision of record keeping in relation to residents intake, as prescribed by their care plan.

Judgment: Not compliant

Regulation 21: Records

Records were not consistently maintained as required by Schedule 2 of the regulations. A review of staff personnel files found that not all files were complete. This was evidenced by:

- One staff member did not have a Garda vetting disclosure on file.
- Two staff files did not have two references.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had failed to ensure that adequate resources had been allocated to the centre to ensure a safe environment for residents. This was evidenced by the lack of a time-bound action plan in relation to the non-compliance observed in the previous inspections in relation to Regulation 17: Premises and Regulation 28: Fire precautions. This posed a risk to the ongoing safety and well being of the residents in the centre.

The organisational structure in the centre was unclear. There was no clear pathway or process of how risk was escalated to the provider. It was unclear who held responsibility and authority to manage the risks identified in the centre. The management team did not ensure that there was documented evidence of risk escalation, or an associated action plan to address these risks.

The management systems in place did not ensure that the service delivered was safe, appropriate, consisted and effectively monitored. This was evidenced by;

- inadequate maintenance of the premise and care environment. The flooring remained in a very poor state of repair. While there was supplier confirmation that the flooring had been ordered, there was no time bound action plan for the refurbishment works to the centre.
- ineffective communication systems between the management team and the provider, with no documented evidence of how risks identified in the centre were escalated.
- inadequate oversight of the record management systems. The staff file audit, committed to by the provider, had not been completed.
- Insufficient clinical governance arrangements in the centre.
- Incomplete systems of monitoring the service. For example, some audits completed did not have an associated action plan developed to ensure quality improvement

Judgment: Not compliant

Quality and safety

Residents reported enjoying a good quality of life in this centre. Staff interactions with residents were consistently observed to be respectful and kind. While the quality of care delivery had improved since the last inspection, some care and fire safety practice remained poor, as described earlier in the report. Notwithstanding the residents' positive feedback, inspectors found repeated non-compliance in the care environment, including fire safety. This inspection found that inadequate standard of governance and management also impacted on the quality of care planning, infection control and residents' rights.

The premises was in a poor state of repair and this had an impact on the safety and well being of the residents. The flooring throughout the centre was damaged and unsightly, was not amenable to effective cleaning, and was a potential trip hazard. The overall upkeep of the premises was inadequate. This issue had been identified over multiple inspections of the centre over the past five years. The provider had committed to upgrading the flooring in the centre, however, no time bound action plan had been submitted.

A review of fire precautions found that arrangements were in place for the testing and maintenance of the fire alarm system, emergency lighting and fire-fighting equipment. Since the last inspection, the provider had engaged the services of an external contractor to conduct a fire safety risk assessment. At the time of inspection the assessment had been carried out, however, the report had not been issued to the registered provider. As a result, the registered provider did not have documented confirmation relating to the compartmentation arrangements for the centre, ensuring the containment of fire in an emergency. This meant that staff

could not evacuate residents to a confirmed place of safety in the event of a fire emergency as it was unknown where a compartment began and ended.

In addition, the registered provider had commissioned a review of all fire doors in the centre by a competent person. This report was reviewed by inspectors and it indicated that the majority of fire doors in the centre required replacement. There was no time bound action plan in place to address this risk.

Staff were familiar with the procedure to be followed in the event of the fire alarm sounding. However, staff remained unclear in relation to the containment measures in the centre. Staff advised that they attended fire drills weekly and drills were clearly documented, however, the lack of clarity in relation to the compartmentation posed an ongoing risks to all occupants of the centre.

Inspectors noted that a window pane on a fire escape at the rear of the building had broken and had been temporarily replaced with cardboard. The management team could not confirm when this window had broken, or the time line for its repair.

Inspectors observed the lunchtime dining experience. The provider had opened a second dining area in one of the day rooms, however, the dining room was unsightly with damaged flooring and furniture. While it had a dining table, the room was not furnished in a manner that would promote an enjoyable dining experience. On the day of inspection, no residents were observed using this room and staff confirmed that it was rarely used. Inspectors noted an improvement in some of the other aspects of the dining room experience since the previous inspection. There were menus displayed in the dining room and in the corridor outside the dining room, and residents were observed to be offered choice in relation to the meals they received. Residents advised that they were asked for their choice of meal in the morning. The meals presented to the residents were appealing and residents were satisfied with the choice and quantity of food on offer. Staff spoken with were knowledgeable about residents' dietary requirements. Inspectors observed that a significant amount of residents continued to have their meals on a tray in the day room or in their bedroom. Staff were not appropriately allocated to ensure residents were supported with their meals. The supervision of these residents while they ate posed a challenge for staff.

A review of a sample of residents' assessments and care plans found that while care plans were detailed, inspectors found that they were not always updated to reflect a resident's assessed needs or preferences. For example, one resident's care plan detailed that the resident enjoyed spending time in the day room; however, this was not reflective of the practice observed or documented in the daily notes of the resident. Staff also confirmed that the resident's needs have changes since the care plan was developed, and that the resident now preferred to spend their day in their bedroom. This was not updated in the resident's care plan. A review of another resident's nutritional care plan found that the residents intake was potentially being impacted by the resident disposing of part of their meal. The staff confirmed that they were aware of this risk, however, this detail was not included in the resident's

care plan and therefore no care intervention had been developed in consultation with the resident to reduce this risk.

There was no formal activity schedule in place. Staff and residents told inspectors that there was normally music once a week and mass preformed every couple of weeks. Residents were observed spending long periods of time in their bedroom without engagement, while other residents were observed spending long periods of time in the day room watching television. A musician attended in the afternoon of the inspection day. This appeared to be an unscheduled activity as staff spoken with were unaware there was music planned for the afternoon. Resident meetings were scheduled and documented, however, a review of the meeting records found that there was no actions documented in response to issues identified by residents at these meetings, for example, a request for more snacks, and more music.

Residents in some of the shared bedrooms were unable to carry out activities in private, as there was a lack of privacy screening. This is a repeated finding from previous inspections.

Infection prevention and control systems were not in line with regulatory requirements. There were two cleaners on duty in the centre on the day of inspection. Cleaning trolleys were organised and secured when left unattended. While some effort had been made to de-clutter and tidy the centre since the previous inspection, the cleanliness of the centre remained inadequate. The poorly maintained surfaces including the floor, walls and furniture could not be effectively cleaned.

Residents had access to their General Practitioner (GP), and residents reported that their GP attended the centre, if requested or required. There were arrangements in place for residents to access the expertise of allied health professionals such as physiotherapy, dietitians, palliative care nurses and tissue viability nurses.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre. The provider did not act as a pension agent for any resident.

The risk management policy had been reviewed and updated to meet the requirements of the regulations. Some identified risks were documented in a risk register, and detailed some of the action taken to control the risks. However, some controls detailed in the risk assessments were not observed to be in place on the day of the inspection.

Regulation 17: Premises

The premises was found to be in a poor state of repair and was not in line with Schedule 6 of the regulations. This was evidenced by:

- Flooring throughout the centre was in a poor state of repair
- Painted surfaces throughout the centre were chipped, peeling and unsightly.
- Equipment for resident use, such as chairs, beds and other pieces of furniture were in a poor state of repair.
- Inadequate storage arrangements in the centre. Resident equipment such as shower chairs, commodes and linen trolleys were stored in a shared bathroom. A hoist and comfort chair was stored in a communal area.
- Poor ventilation in the smoking room caused a strong odour of smoke in the day room.
- The external premises was not maintained to ensure resident safety.

Judgment: Not compliant

Regulation 18: Food and nutrition

While there was notable improvements in the dining experience within the existing dining room, the arrangements at mealtimes meant that some residents was poorly supervised and monitored in relation to their nutritional risks. This is a repeated non-compliance from a previous inspection.

Judgment: Substantially compliant

Regulation 26: Risk management

While improvements were noted in the overall risk management policy, and the documentation of identified risk, some controls detailed in the risk register had not been addressed. For example, a risk assessment in relation to the smoking room stated that there was a fire extinguisher in the smoking room, however, this was not observed on the day of the inspection.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control systems were not in line with regulatory requirements. Flooring throughout the centre was damaged and could not be effectively cleaned.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider did not have adequate arrangements in place for the containment of fire. This was evidenced by:

- Some doors with magnetic operated door closers were observed to be wedged open.
- A cross-corridor fire door did not release when tested.
- Multiple fire doors were observed to be damaged and in a poor state of repair.

The provider had not ensured that staff had received suitable fire training, as was committed to in an urgent compliance plan, submitted to the Chief Inspector following the previous inspection.

Staff were not aware of the compartmentation arrangements in the centre. The registered provider had been issued with an urgent compliance request to address this issue in March 2026. This had not been completed. This posed a significant risk to the safety of residents, staff and visitors to the centre by impacting on the effectiveness of staff training, evacuation drills, and fire containment measures..

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessments and care plans found that they were not fully in line with the requirements of the regulations. This was evidence by;

- Care plans were not always updated to reflect residents' preferences. For example, a resident's care plan stated that they liked to spend time in the day room when it was known to staff, and observed by inspectors, that they preferred to spend most of their day in their bedroom.
- Care plans were not always updated to accurately reflect the residents assessed needs. For example, a resident's nutritional care plan did not

contain the required detail to guide staff in how to manage their nutritional care needs.
Judgment: Substantially compliant
Regulation 9: Residents' rights
The provider had not ensured that residents could carry out personal activities in private. This was evidenced by some shared bedrooms not having adequate privacy at their bed space. This is a repeated non-compliance. The provider had not provided sufficient opportunities for residents to participate in activities, in accordance with their interests and capacities. While resident meetings were scheduled and documented, there was no evidence that any action plan had been put in place to address residents' requests.
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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Rosemount House Nursing Home OSV-0004583

Inspection ID: MON-0050641

Date of inspection: 04/06/2026

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have been retrained and are up to with Fire Training and Manual Handling Training. Twice daily checks are undertaken and recorded of all doors in the service to ensure no doors are wedged open. The risk of doors being wedged open is reiterated during all safety pauses and handovers. Any staff members which continue to engage in this practice will be met with and proceedings will be followed as per in-house policy. In the post-morning handover staff are allocated to have oversight of all dining areas including residents who choose to have their meals in their bedrooms. A paper document has been introduced which enables the staff to document immediately individuals' fluid and nutritional intake prior to them entering the details in the electronic system. The CNM having oversight of the same.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The member of staff whose Garda vetting was identified as missing during the inspection was removed from the roster. A repeat Garda vetting was undertaken and has been received. The staff member was reinstated on the roster. All current staff files are being audited by the Administrator and any identified outstanding documentation is being requested to ensure full compliance with the Regulation. The GM will provide oversight	

and monitor the completion of the audit and any outstanding actions.

All current staff have up to date Garda vetting and required documentation. A employment checklist has been implemented to ensure that all required documentation is obtained and verified any new staff member commences employment. The administrator will complete a full audit of all staff personnel files to ensure full compliance with the requirements. The GM will provide oversight and monitor the completion of the audit and any outstanding actions.

Regulation 23: Governance and management

Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Providers acknowledge the findings of the inspection and accept that improvements are needed to strengthen the governance and management of the designated centre. They are fully committed to providing the resources needed to achieve compliance and to ensure the ongoing safety, wellbeing and quality of care for all residents.

A clear, time-bound action plan has been put in place to address the outstanding works under Regulation 17 (Premises) and Regulation 28 (Fire Precautions). The replacement of the flooring throughout the centre will begin on 10 August 2026 and is expected to take between four and six weeks to complete. The installation of the required fire doors will commence on 7–8 September 2026 and is expected to take a further four to five weeks. The Providers will closely monitor the progress of these works to ensure they are completed within the agreed timeframes.

To improve communication and oversight, the Providers now hold fortnightly Zoom meetings with the Person in Charge (PIC) and the General Manager (GM) to review compliance, monitor progress on action plans and discuss any risks or concerns. In addition, two Directors carry out a monthly walkaround of the centre with the PIC and GM to review the premises, identify any issues and agree actions with clear responsibilities and completion dates.

A more structured risk escalation process has also been introduced. Any risks identified within the centre are now documented, reported to the Providers promptly and monitored until they have been addressed. Minutes of governance meetings are maintained, with agreed actions, responsible persons and target completion dates clearly recorded.

The outstanding staff file audit is now underway and will be completed within the agreed timeframe. Any issues identified will be addressed without delay. Audit processes have also been improved to ensure that every audit includes a clear action plan, identifies who is responsible for each action and includes follow-up reviews to confirm that improvements have been completed.

Clinical governance has also been strengthened through increased oversight by the PIC

and management team. Clinical audits, incidents, risks and quality improvement actions are now reviewed on a regular basis to ensure the service is monitored effectively and that improvements are identified, implemented and sustained.

Regulation 17: Premises

Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Flooring commencing on 10th August 2026 with an approximate completion time of four weeks. Fire doors commencing 7th / 8th September 2026 with completion estimated within four weeks. A complete programme of redecoration works throughout the service will take place as soon as each section of the building has the fire doors installed. A timeline schedule will be provided once fire door works commence. The roof has been cleaned and treated for moss. Landscaping works are continuing.

Regulation 18: Food and nutrition

Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

A third dining area has been introduced to provide residents with greater choice regarding where they wish to dine, based on their individual preferences and whether they choose to dine in the company of other residents. This initiative has been well received, with residents providing positive feedback regarding the enhanced dining experience. A monthly dining experience audit and associated quality improvement plan remain in place to monitor the effectiveness of mealtime and identify opportunities for ongoing improvement. Following the morning handover, the nurse in charge allocates staff to each dining area, including residents who choose to dine in their bedrooms, ensuring appropriate supervision and assistance throughout mealtimes. To strengthen oversight and accountability, a paper-based staff allocation and sign-off sheet has been introduced. Staff are required to sign this immediately before completing the electronic record, enabling the CNM to maintain effective oversight of staff and supervision arrangements during mealtimes.

All residents' care plans have been reviewed and updated to reflect any changes in their current nutritional status, nutritional risks, and required interventions.

Residents continue to be actively consulted regarding their meal preferences, with suitable alternatives offered in accordance with their wishes. These measures support person-centered care while ensuring residents requiring nutritional support are appropriately supervised and monitored during mealtimes.

This version is written in a regulatory style, clearly addresses the repeated non-

compliance, and demonstrates the governance measures implemented to prevent recurrence.	
Regulation 26: Risk management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management: The homes risk register has been reviewed and updated to ensure that all identified risks are accurately recorded, assessed, and supported by appropriate control measures. A fire extinguisher has been installed in the designated smoking room to enhance fire safety and ensure appropriate emergency equipment is available. The providers have strengthened governance and oversight arrangements by implementing fortnightly Zoom governance meetings and monthly on-site management meetings. During the monthly visits, the providers will complete a walkaround of the premises to identify environment and operational risks, review control measures, and monitor progress on quality improvement initiatives. Any high-level risks identified will be escalated to the providers without delay. Appropriate control measures will be implemented immediately to mitigate identified risks, with ongoing monitoring to ensure the effectiveness of actions taken and to maintain a safe environment for residents and all people in the centre	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: The majority of our staff have had IPC training, with the remainder attending training on 7th August 2026. We have appointed an IPC Lead and she is conducting quarterly IPC audits. The domestic staff have both a deep clean schedule and a daily cleaning schedule the CNM is responsible for the oversight of this. The managers are observing one member of staff during their daily walkabout with their handwashing technique and whether the correct use of PPE is being applied. The floors are continually cleaned throughout the day however, the bad state of the surface of the floors doesn't improve the appearance.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Twice daily walkabout is undertaken to ensure no fire doors are obstructed or wedged open. Discussion take place with all staff member during handover and safety pause. 47 doors are being replaced in the home commencing 7th/8th September 2026. The majority of staff have been retrained with the remainder having training on 28th August 2026. We are awaiting information from Phoenix STS on the compartmentation of the building. The building is scheduled to be scanned (date to be confirmed) whereupon correct floor plans showing compartmentation will be provided. Oxygen tanks have been removed from the internal of the building and placed in a secure oxygen cage outside the building.	
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: All residents care plans have been reviewed and updated to accurately reflect any changes in their assessed care needs, ensuring that care is individual to the resident, person-centred, and responsive to residents current requirements and will be updated pending their changing needs. Staff nurses have received guidance and support regarding care planning through individual discussions and dedicated Lunch and Learn sessions. These sessions focused on improving the quality of assessments, documentation, and care planning to ensure that residents' needs are reflected in their care plans and that care is delivered consistently and effectively by staff. the CNM will complete monthly care plan audits, with oversight and support provided by pic. Audit findings will be reviewed, and any identified actions will be addressed promptly to promote continuous quality improvement and ongoing compliance.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Disposable privacy curtains are being sourced date for delivery to be confirmed. As an interim measure, a portable privacy screen is available and is used whenever residents require additional privacy, ensuring their dignity and privacy are maintained at all times. A new Activities Coordinator has been appointed and is actively engaging residents in	

meaningful, person-centred activities. A Residents' Forum was held to consult with residents regarding their activity preferences and interests. Feedback from this forum has informed the development of an activity schedule that reflects residents' choices and promotes meaningful engagement. To further enhance the provision of social and recreational opportunities, a second Activities Assistant is due to commence employment during the week beginning 10 August 2026. This additional staffing resource will support the delivery of a broader range of activities and increase opportunities for individual and group participation in line with residents' will and preferences

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	28/08/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/07/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2026
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	31/07/2026

Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/08/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	21/09/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/07/2026
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.	Not Compliant	Orange	31/07/2026

Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	31/07/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	21/09/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/07/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/08/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	20/10/2026

	maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	20/10/2026
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.	Not Compliant	Orange	28/08/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is	Substantially Compliant	Yellow	28/08/2026

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	21/09/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	28/08/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	23/07/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Substantially Compliant	Yellow	03/08/2026

	activities in accordance with their interests and capacities.			
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	03/08/2026
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/06/2026