Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Annabeg Nursing Home
Name of provider:	Costern Unlimited Company
Address of centre:	Meadow Court, Ballybrack, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	05 February 2026
Centre ID:	OSV-0000005
Fieldwork ID:	MON-0041862

About the designated centre

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

Annabeg Nursing Home is situated in a quiet cul de sac in Ballybrack. It is registered for 41 beds and offers both single and twin room accommodation. Annabeg accommodates both male and female residents over the age of 18. The centre offers long and short-term care, and provides care for low dependency, medium dependency, and high/maximum dependency residents. Costern Unlimited Company is the registered provider, and the person in charge is supported by the management team, an assistant director of nursing, nursing staff and healthcare assistants. Residents have access to a number of communal rooms (three in total) and a family/visitors room. There are two passenger lifts & an enclosed courtyard is a 'timeout' haven for residents to enjoy. Annabeg is currently serviced by the Cherrywood Luas, Killiney Dart Station and local buses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

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 5 February 2026	08:15hrs to 16:35hrs	Aisling Coffey	Lead
Thursday 5 February 2026	08:15hrs to 16:35hrs	Frank Barrett	Support

What residents told us and what inspectors observed

The consistent feedback from all residents who spoke with the inspectors was that they greatly liked living in Annabeg Nursing Home. The residents spoken with were highly complimentary of the centre, the staff and the care received. With regard to the staff who cared for them, one resident told the inspectors, "the staff are lovely", while another remarked, "they're all gorgeous", and a third resident told the inspectors about the "good laughs" between residents and staff. Residents also expressed high praise for the activities available and the food served. Visitors spoken with were similarly complimentary of the care received by their loved ones, the communication with them as a family, and the confidence it gave them that their loved ones were being well cared for. The inspectors found that staff and management were knowledgeable about residents' needs, and that they promoted and respected residents' rights and choices. The inspectors observed numerous compassionate, warm, dignified, and respectful interactions between residents and staff throughout the day of the inspection.

Two inspectors of social services conducted this unannounced inspection over one day. During the inspection, the inspectors chatted with many residents and had the opportunity to speak in more detail to 10 residents and two visitors to gain insight into the residents' lived experience in the centre. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

The premises consist of a two-storey period house with an adjoining three-storey extension added in 2015. The centre is laid out over three floors, with stairs and two passenger lifts, facilitating the movement of residents, visitors, and staff between floors.

The centre's design and layout supported residents' movement throughout, with sufficient handrails to accommodate those using mobility aids. There were several communal areas available for residents to use, including a lounge off the main reception area, which displayed residents' artwork and pottery. There was also a ground-floor TV room, where residents relaxed watching television and listening to music. On the first floor, there was a private visitor's room with tea and coffee-making facilities. The ground floor had been extended since the inspection in August 2024, and residents now had access to a large, open-plan area that benefited from natural light and offered views out to the garden. The provider had registered this extension as a dining room; however, on the inspection day, it was observed to operate as both a dining room and a lounge . The previously designated dining room, which had been registered as a lounge, was observed operating as a dining room on the inspection day. The provider had informed the Office of the Chief Inspector of these changes in function prior to the inspection. Residents who spoke

to the inspectors confirmed that they preferred to use the bright, open-plan area as a lounge and wished to continue taking their meals in the former dining room.

The centre was seen to be pleasantly and thoughtfully decorated throughout. The communal areas featured attractive furnishings and domestic features, such as fireplaces, delph dressers and antique radios, providing residents with a homely environment. The centre also displayed memorabilia from the past in multiple display cabinets, featuring critical historical, sporting and musical events, ranging from the Easter Rising, to county and provincial sporting victories.

There was an on-site laundry service that laundered residents' personal clothing. This area was noted to be clean and tidy, and its layout supported the functional separation of the clean and dirty phases of the laundering process.

Bedroom accommodation comprised 29 single bedrooms and 6 twin bedrooms. The majority of bedrooms, except for one single and three twin bedrooms, had en-suite facilities that included a shower, toilet, and wash hand basin. Residents without en-suite facilities had access to shared toilets and showers. Bedroom accommodation throughout the centre had a television, call bell, wardrobe, seating, and locked storage facilities. Residents had personalised their bedrooms with photographs, artwork, religious items, and ornaments. The size and layout of the bedroom accommodation were appropriate for residents' needs. Residents whom the inspectors spoke with were pleased with their bedrooms and personal space.

The centre's internal courtyard garden was clean, tidy, and pleasantly decorated. This courtyard area had comfortable seating, garden decorations, raised flower beds, potted plants and flowers. This area was not in use on the inspection day due to wet weather.

While walking the premises, inspectors observed inappropriate storage and areas requiring repair. This is discussed under Regulation 17: Premises. Additionally, inspectors met a representative from a fire safety company, who was surveying the premises' doors to carry out fire safety upgrade works. Inspectors noted an immediate risk preventing a fire door from operating, as well as other concerns that required upgrades to enhance fire safety. This and further fire safety findings are discussed under Regulation 28: Fire precautions.

On the morning of the inspection, residents were up and dressed in their preferred attire, appearing well cared for. The centre had an activities programme which took place over seven days. On the inspection morning, a one-to-one activity, including hand massage and nail care, was taking place in the open-plan sitting and dining area. Refreshments, including soup, tea, coffee, home-made scones and biscuits, were served mid-way through the morning at 11:00am. After lunch, there was a game of bingo in the lounge adjacent to reception, followed by pet therapy. Residents in the open-plan area played cards, read newspapers and listened to music in the afternoon. Some residents were seen relaxing in their bedrooms, according to their preferences. These residents watched television, listened to the radio, read newspapers and books, or used the centre's internet services. All

residents who spoke to the inspectors expressed high praise for the activities programme and entertainment available.

Visitors were observed coming and going throughout the day, spending time with their loved ones in the multiple comfortable communal areas. Residents and visitors confirmed there were no restrictions on visiting.

There were two lunchtime sittings at 12:00pm and 1.00pm. Lunchtime was observed to be a sociable and relaxed experience, with residents eating in the dining room and the new open-plan sitting and dining area. Meals were freshly prepared in the centre's onsite kitchen and were freshly plated for residents by the chef from a bain-marie. Residents were offered a choice of two main courses: roast pork with apple sauce, stuffing and gravy or pan-fried sea trout with tomato sauce. There were also a number of dessert options available after the main meal, including pineapple upside-down cake. In the evening, residents were seen to enjoy a choice of shepherd's pie or scrambled eggs and tomato. There were ample drinks available for residents at mealtimes, and further drinks accompanied by snacks throughout the day. Each bedroom was seen to have jugs of fresh drinking water available for residents. Staff provided discreet, respectful dining assistance to residents who required it. Residents spoke positively to the inspectors about food quality, quantity and variety and stated they were also pleased with the timing of meals.

The following two sections of the report present the findings of this inspection regarding the centre's governance and management arrangements and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

While governance and management systems were in place to oversee the quality of care delivered to residents, the oversight systems to ensure the centre was safe from the risk of fire and operating in line with its policies were insufficient. This will be discussed under Regulation 23: Governance and management and Regulation 28: Fire precautions.

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The centre had been previously inspected on 20 August 2024, 01 October 2024 and 04 July 2025. This inspection reviewed the registered provider's compliance plan from the inspection of 20 August 2024 and found regulatory compliance was improved across many areas, including managing challenging behaviour and infection control. However, some areas reviewed on this

inspection did not fully meet the regulatory requirements and will be further discussed in this report.

An immediate action was issued on the morning of the inspection concerning fire containment measures. Inspectors found the door from the entrance corridor into the residents' sitting and dining areas was held open by a screw in the doorframe. This adjustment to the door frame meant the door would not close, leaving residents unprotected from fire and smoke in the event of a fire alarm activation. Additionally, the boiler room was being used to store builders' materials, including paints. The provider addressed these issues immediately when they were brought to their attention. Following the inspection, a letter was issued to the provider requesting confirmation that these practices were no longer occurring and confirming that the provider had alerted staff to the associated risks. This letter also requested that action be taken to implement a fire safety policy, ensure staff were aware of it, and ensure it was implemented in practice. The providers' response to this letter provided assurance to the Chief Inspector that corrective action had been taken. While the provider was carrying out regular fire safety checks and audits at the centre, these immediate and ongoing risks were not being identified. This is discussed further under Regulation 23: Governance and Management.

Costern Unlimited Company is the registered provider. This provider owns and manages several designated centres in Ireland. There are two directors in this company, one of whom represents the provider for regulatory matters.

In July 2025, there were two changes to the centre's governance and management structure: a change in the person in charge and the appointment of a second participant in management, a regional operations manager. This is a senior manager who supports the person in charge in their operational management and clinical oversight of the centre. The person in charge was not working on the day of the inspection; however, the regional operations manager was present throughout the day to support the inspection process and to receive feedback at the end of the day.

There was a clearly defined management structure which identified lines of accountability and responsibility for the service. The person in charge was responsible for the centre's day-to-day operations and reports to the regional operations manager, who in turn reports to the board of directors. The person in charge worked full-time at the centre and was supported by an assistant director of nursing, a team of nursing and healthcare assistants, activity coordinators, chefs, catering, housekeeping, laundry, maintenance, and administration staff. The assistant director of nursing deputises for the person in charge in their absence. Where the assistant director of nursing is also absent, a senior nurse deputises with the support of the person participating in management, as was observed on the inspection day.

The registered provider had systems in place to monitor the quality and safety of care. There was documentary evidence of the communication systems in place between the person participating in management and the person in charge. Minutes of governance meetings were reviewed by the inspectors. These meetings discussed key aspects of care provision for residents, including staffing, facilities, fire safety,

incidents, and clinical care. Within the centre, there was evidence of regular staff meetings focusing on key aspects of quality and safety, such as staffing, record-keeping and clinical care. The provider also had targeted staff meetings focusing on health and safety and infection control.

The provider had systems to oversee accidents and incidents within the centre. The provider had undertaken regular auditing of multiple areas, including medication management, care planning, safeguarding, and call bell response times. The person in charge had conducted out-of-hours visits to the centre during the summer of 2025, which identified areas for improvement concerning the environment and resident care. Action plans following these visits were seen to have been implemented. Despite these systems being in place, the inspection found that oversight mechanisms did not effectively identify all deficits and risks in service provision, and therefore did not drive quality improvement in some areas. This will be discussed under Regulation 23: Governance and management.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2025. The inspectors saw evidence of the consultation with residents and families reflected in the review. In this review, the registered provider also identified areas requiring improvement and was in the process of actioning these.

Regulation 14: Persons in charge

While the person in charge was an experienced registered nurse with previous management experience and held post-registration management qualifications, as they were not named on the register maintained by the Chief Inspector on or before 31 March 2025, they did not have either:

- a post-registration management qualification in health or a related field at a minimum of Level 8 qualification on the National Framework of Qualifications or
- a nursing post-graduate qualification at a minimum of Level 9 on the National Framework of Qualifications, which includes a management or leadership module.

Therefore, this person in charge was required to obtain further education before 31 March 2028 to comply with the regulation.

Judgment: Compliant

Regulation 15: Staffing

Based on a review of the worked and planned rosters and speaking with residents, it was evident that there was sufficient staff with an appropriate skill mix on duty each day to meet the residents' assessed needs. There was one registered nurse in the centre at night.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Records made available to the inspectors found that staff members were up to date with mandatory training in fire safety, infection control, managing challenging behaviour, and safeguarding vulnerable adults from abuse.

The inspectors saw documentary evidence of the provider's staff appraisal system. Records reviewed found the provider had arrangements for assessing a staff member's competency and reviewing their performance at set intervals.

Staff were appropriately supervised and clear about their roles and responsibilities.

Judgment: Compliant

Regulation 19: Directory of residents

The provider established and maintained an electronic-based directory of residents in the designated centre. This directory recorded information required under Schedule 3 of the regulations, including the resident's admission date, contact details for the next of kin and the general practitioner.

Judgment: Compliant

Regulation 23: Governance and management

While the registered provider had several systems in place to monitor the quality and safety of the service provided, these systems were not fully effective in identifying all risks and driving quality improvement in areas such as individual assessment and care planning, premises, and fire precautions, as outlined in the report.

The oversight of fire safety systems had not identified areas essential to ensuring that residents were safe from the risk of fire and that staff had received appropriate

training in the prevention and management of fire. This was evidenced by the following:

- On the day of the inspection, no fire safety policy was available for the inspectors to review. This policy would set out the provider's objectives for protecting residents from the risk of fire. Other documents referred to the fire safety policy; however, throughout the day, this could not be located. Following the inspection, the provider was requested to put in place a policy that reflected the centre, its residents, and the available resources to limit the risk of fire. The provider located the policy in the days after the inspection and provided evidence that staff had been made aware of its existence, content, and location, and that further action would be taken to ensure it was implemented in practice.
- The registered provider had not ensured that a fire safety risk assessment had been completed by a trained external fire safety professional. Consequently, significant fire safety issues were identified during this inspection, requiring immediate actions by the provider to address modifications to a fire door and flammable storage in the boiler room. The provider committed to engaging a fire safety specialist consultant to identify fire safety issues and put a time-bound action plan in place to address the findings.
- While a modern fire detection and alarm system was in place, the fire alarm system's classification was unclear, with the documentation containing conflicting information. While some documentation identified the system as a category L1, recent service records indicated the system as an L2/L3. A category L1 system provides assurance that detection is available in all areas, thereby minimising the time between a fire starting in any location and the alarm sounding.

Management systems to ensure that residents' finances were managed in accordance with the provider's policies were not sufficiently robust. For example:

- The inspectors found that one staff member was receiving residents' funds for safekeeping and issuing those funds to residents upon request. This practice was contrary to the provider's policies, which require two staff members to be involved in these processes.
- The inspectors found that the provider had small quantities of cash, ranging from €10 to €50, belonging to four deceased residents who had died between 2021 and 2023, in the provider's possession. There were no records available to demonstrate that the provider had contacted the residents' representative regarding these funds in accordance with the provider's policies.

Oversight systems in place to ensure the implementation of the falls policy were ineffective, as on three occasions, neurological observation assessments were not monitored and documented in accordance with the provider's falls policy following an unwitnessed fall.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of four residents' contracts and found that they set out the allocated bedroom number and occupancy. The contracts outlined the services to be provided and the fees to be charged, and referenced other services that residents may choose to avail themselves of at an additional cost, such as hairdressing.

Judgment: Compliant

Quality and safety

The inspectors observed kind and compassionate staff treating residents with dignity and respect. Residents were protected from harm and their rights were upheld in the centre. Residents received food and nutrition in line with their dietary needs. The centre was very clean, visiting was encouraged, and residents were able to retain control over their possessions. Notwithstanding these very positive aspects, some actions were required regarding individual assessment and care planning, health care, premises, and fire precautions, as outlined in the report.

The inspectors reviewed a sample of nursing notes and care plans for residents. There was evidence that residents were comprehensively assessed upon admission using a suite of evidence-based risk assessment tools to evaluate risks, including falls, pressure sore development, malnutrition, manual handling needs, and dependency levels. Care plans viewed by inspectors were person-centred and specific to that resident's needs. Care plans were reviewed at required intervals, and there was evidence of consultation with the resident and, where appropriate, their family during these reviews. Notwithstanding this good practice, the inspectors found that some residents with assessed needs did not have a care plan developed to manage these needs. This is discussed under Regulation 5: Individual assessment and care plan.

Overall, the premises' design and layout met residents' needs. The centre was found to be appropriately decorated, clean and in good repair overall internally and externally. The centre had a well-maintained internal courtyard garden. However, action was required to ensure full compliance with Schedule 6 requirements and to ensure that the premises were in line with the statement of purpose and the floor plans for which it is registered. The recent ground-floor extension provided an enhanced open-plan day space for residents. However, this open-plan space included a thoroughfare section of corridor, which could not be used by residents. The communal space available to residents for eating, relaxing, visiting, chatting, and participating in activities was limited. Some residents carried out all of these

daily activities within the same space. This will be discussed under Regulation 17: Premises.

A review of the measures in place to protect residents from the risk of fire was completed by inspectors during this inspection. The centre was equipped with a serviced fire alarm system, emergency lighting, and fire extinguishers, and staff were knowledgeable about the use of evacuation aids to assist residents in evacuating in the event of a fire. Fire safety training and fire drills carried out at the centre reinforced the practice of progressive horizontal evacuation, which relies on effective compartmentation or separation within the building. This practice allows residents to be moved from one area to another within the building in the event of a fire, before being evacuated externally if necessary. However, significant fire safety containment concerns were noted, which would impact the relative safety of the next compartment in many cases, and required review. This and other fire safety concerns are discussed under Regulation 28: Fire Precautions.

Regulation 11: Visits

The provider had a written visitor policy as required by the regulation. The inspectors observed that visits to the centre were encouraged. The visiting arrangements in place did not pose any unnecessary restrictions on residents. The registered provider had a private visiting room on the first floor and other communal spaces for residents to host a visitor.

Judgment: Compliant

Regulation 12: Personal possessions

There were arrangements to support residents in accessing and retaining control over their personal property, possessions, and finances. Residents' clothes were laundered onsite. Residents had adequate space in their bedrooms to store and maintain their clothing and possessions, including access to locked storage facilities. Residents who spoke with the inspectors stated they were satisfied with the space in their bedrooms, storage facilities available, and the laundry service.

The provider was a pension agent for two residents and managed small quantities of funds for a further seven residents. Records reviewed found that these pensions were paid into a separate residents' client account to safeguard residents' finances. The provider had a transparent system in place for recording lodgements and withdrawals of residents' personal monies from their accounts. The inspectors found evidence that the residents' funds were made available to them as required.

Notwithstanding this good practice, the provider's systems required strengthening to ensure that residents' finances were managed in accordance with the provider's policies, as discussed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 17: Premises

The registered provider was required to ensure that the premises are in line with the statement of purpose and the floor plans for which it is registered. For example:

- The provider was using external storage on the centre's grounds to store residents' consumables, such as incontinence wear. However, this storage facility was not included in the centre's floor plans and was therefore not currently registered for use as part of the centre's day-to-day operations.
- The second-floor linen store had changed function to a kitchen store, with dried food and crockery being stored.
- The new open-plan communal space on the ground floor had been registered as a dining area but was operating as both a dining and a lounge area on the inspection day. The registered lounge was observed operating as a dining room. Some residents were seen spending their day in one location, eating, relaxing, hosting visitors, and participating in activities. A further review of communal space was required to ensure that residents' choices, dignity, privacy and comfort were upheld.

Having regard to the needs of the residents at the centre, the registered provider had not ensured that all areas of the premises conformed to the matters set out in Schedule 6 of the regulations, for example:

- There was a roof leak, and inspectors found a large container collecting water from it in a stairwell. The provider was assessing the damage and organising repairs. The provider updated the inspectors after the inspection regarding the ongoing remedial works and provided an estimated completion date for these works.
- Inspectors found examples of inappropriate storage arrangements, for example, three boxes containing clothing and resident possessions were stored in the salon, while a rollator, two wheelchairs and a pressure cushion were stored in a shared ensuite bathroom.
- The mobility equipment for one resident was not kept in good working order. This resident was observed mobilising using a steel-framed zimmerframe, which made a continuous high-pitched noise as they walked through communal areas. This noise was not conducive to creating a calm and comfortable environment for residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were highly complimentary regarding food, snacks, and drinks. Food was prepared and cooked onsite. Choice was offered at all mealtimes, and adequate quantities of food were provided during the day and in the evening. Residents had access to fresh drinking water and other refreshments throughout the day. There was adequate supervision and discreet, respectful assistance at mealtimes. There was evidence of written communication between the nursing and catering teams to ensure that the dietary needs of each resident, as prescribed by healthcare or dietetic staff, were met.

Judgment: Compliant

Regulation 27: Infection control

The provider had systems in place to oversee infection prevention and control practices within the centre. The centre's interior was very clean. Surveillance of healthcare-associated infections and multi-drug resistant organism colonisation was being undertaken and recorded. The provider had appointed a trained infection control link nurse to provide specialist expertise, and staff had access to IPC training. A targeted auditing system was in place to regularly review staff practices and environmental cleanliness. The person in charge had completed a review following a recent Respiratory Syncytial Virus (RSV) outbreak. During the review, relevant protocols and guidance were documented as having been adhered to, and learning was identified for a future outbreak.

Judgment: Compliant

Regulation 28: Fire precautions

Inspectors observed that some areas of fire safety did not align with regulatory requirements and provide residents with appropriate protection against the risk of fire, for example:

- Builder's materials, including door fittings and paint, were stored in a boiler room. The boiler room is a high fire risk area, and using it as a storage space for high fire risk items poses an additional fire risk to the centre. These items were removed on the day when this issue was highlighted to staff.

The means of escape were inadequate on the day of the inspection, for example:

- Obstructions were found on the means of escape. There was a large bin collecting water in a stairwell that partially blocked the stairs. Trollies were observed stored in a corridor space near the laundry overnight outside bedroom 1. This practice partially blocked the escape route from bedroom 1.

The arrangements in place to detect or contain fires were inadequate on the day of the inspection, for example:

- Significant containment concerns were noted, affecting the centre's compartmentation. The doors to the stairwell in one area did not have the characteristics of fire doors. This stairwell linked resident bedrooms on the ground floor with other bedrooms on the first floor. This meant that residents on both floors were at risk in the event of a fire, without the added protection provided by the fire doors in the stairwell. This was not reflected in staff training, drills, or in management's understanding of the fire evacuation procedure. Additionally, there was no door at the bottom of the above-mentioned stairs to protect the stairs from the staff kitchen area. This area was high risk, as fire, smoke, and fumes would spread directly into the stairwell. The bedroom corridors on the ground and first floors were not effectively protected from this risk.
- The communications (comms) room on the first floor was not effectively separated from the protected escape route due to a passive ventilation grill fitted in the door. This meant that a fire starting in the comms equipment was not prevented from spreading to the escape route, which included bedroom corridors.
- Attic hatches on the first floor were not fire-rated and opened into a large attic space that appeared to be used for storage. This would provide a route for fire, smoke and fumes to spread across compartment ceilings and into the attic space, or into the escape route from the attic.
- There was a set of sliding doors which closed off the dining room. These doors did not appear to be fire-rated. Similarly, a folding section of doors separating the main communal space from the lounge adjacent to the reception area did not appear to have any automatic closing mechanism in the event of a fire in either space.

The registered provider did not make adequate arrangements for the staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout, and escape routes. For example:

- While there were regular fire drills at the centre, further attention to the nature and layout of the centre was required during these drills to ensure that staff understood the requirements for vertical evacuation using the stairs, given the issues noted regarding the separation between the floors.
- Floor plans were not posted on the walls near the fire alarm panel to help identify the location of a fire. Floor plans would also assist residents, staff, and visitors in locating fire escape routes, fire-fighting equipment, compartment boundaries, and the assembly point.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While comprehensive person-centred care plans were developed based on validated risk assessment tools, a sample of reviewed care plans had not been updated to accurately reflect the resident's assessed needs. For example, three residents assessed as high risk of developing a pressure ulcer did not have this risk, nor the measures necessary to control it and enhance the residents' comfort and safety, documented in their care plans.

Judgment: Substantially compliant

Regulation 6: Health care

The health of residents was promoted through ongoing medical reviews and access to a range of external community and outpatient-based healthcare providers, including chiropodists, dietitians, and speech and language therapists. Residents also had access to an in-house physiotherapist once per week.

Judgment: Compliant

Regulation 8: Protection

Systems were in place to safeguard residents and protect them from abuse. Staff were subject to An Garda Siochana (police) vetting before commencing employment in the centre.

Safeguarding training was provided online, and the provider had also commenced a face-to-face training programme. The provider had a safeguarding policy to support and guide staff in recognising and responding to allegations of abuse.

From the records seen, it was clear that the person in charge had provided a robust and person-centred response when investigating and responding to allegations of abuse concerning residents.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that residents' rights were upheld in the centre. Staff were seen to be respectful and courteous towards residents. Residents' privacy in their bedrooms was respected. The centre celebrated in-house religious services monthly, and a Eucharistic Minister visited weekly.

Residents had access to radio, television and newspapers throughout the centre. Residents could communicate freely, having access to telephones and internet services throughout the centre. Residents had access to independent advocacy services, and records reviewed indicated that some residents had utilised these services.

Facilities were available for residents to engage in occupation and recreation. There was a varied and interesting activities programme, including pottery classes, pet therapy, and aromatherapy.

Residents had the opportunity to be consulted about and to participate in the organisation of the designated centre through regular residents' meetings and completing questionnaires.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Annabeg Nursing Home OSV-0000005

Inspection ID: MON-0041862

Date of inspection: 05/02/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and 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:

• The PIC is ensuring that all precautionary measures and risk assessments carried out daily in line with Fire Safety Policy.

• PIC and Provider ensure residents are safe from risk of fire and that staff have received training in the prevention and management of fire. Following days after the inspection, Fire Safety Policy was made available to the Inspectors, the Fire Safety Policy is in place uploaded onto Epic care for all staff to read.

• NH administrator and PIC work alongside auditing and checking the training matrix to identify any gaps for all staff in relation to mandatory trainings including Fire Safety and Evacuation. Meetings are held every Monday with the HR team to discuss any issues relevant to training needs.
Training schedules are communicated to all staff members and feedback sought after these trainings.

• Fire Safety Risk assessment/audit is completed monthly by the PIC to ensure that issues and other risks are mitigated or resolved.

• PIC ensures that "Fire Safety Daily Checklist" is completed daily and at night-time by the Duty Fire officer and any items identified that are not compliant are reported to PIC and immediately actioned or resolved within the NH. This is further escalated to the Head of Facilities and other departments if not resolved at a local or internal level.

• Checklist for Fire Safety Management Documentation has been developed.
• Emergency Evacuation and Response plan is kept up to date; posters are visible in the NH to ensure that information is clear to all.
• Ventilation grill – Flame Stop, risk assess and provide quote on remedial works. Facilities department to engage with an external provider.

• Fire Safety Risk assessment by external personnel as identified at the Inspection had been addressed with the facilities department.
• Modifications to a fire door and flammable storage in the boiler room works completed following the inspection.

• PIC and ADON - A safety checklist in place for storage of combustibles.
PIC is sourcing cabinets for chemicals and combustible materials.
A review of unused equipment stored will be carried out. Designated areas for storing any flammable or hazardous chemicals will be organised and a risk assessment completed.

• The registered Provider had not ensured that a Fire Safety Risk assessment had been completed by a trained fire safety professional. – An external fire safety consultant had been contacted to carry out Fire Risk Assessment to follow up actions as stated – 30July 2026.

• The fire alarm's classification system was unclear, with the documentation containing conflicting information. While some documentation identified the system as a category L1, recent service records indicated the system as L2/L3. – The system is an L1 system, contractor mistakenly on the day of the inspection classified it to L2 rather L1. Going forward it will be listed as L1 by service provider. – completed.

• On the day of the inspection the screw on the doorframe was removed. Safety checks are carried out daily, all staff are informed at daily huddles.

Management Systems to ensure that resident's finances were managed in accordance with the provider's policies were not sufficiently robust:

• On the day of the inspection, it was found that one staff member was receiving funds for safekeeping and issuing those funds to residents upon request. PIC ensured that all staff read and adhere to the provider's policies on "Management of Resident's Accounts and Property to increase awareness and increasing vigilance on handling and management of resident's monies, properties, personal items or valuables kept in the resident's possession or in the safe of the NH for safety.
• When a resident is discharged and or have passed away, The PIC and the NH administrator ensure to inform the NOK or their decision-making representative to collect any money or valuables kept in the safe as these are going to be returned. The Administrator prepares relevant document to be signed by the administrator, witnessed by a second staff member and the signed by the NOK to acknowledge receipt of the items or the money.
• The nurse ensures to document in the care plan regarding return of the money and or any valuables kept in the safe.
• PIC ensures that all residents admitted in the NH have these procedures and policies explained and recorded in the "Resident's Property and Valuables (Safe) Record".
• All NOK and or their representative should sign this record where possible. PIC ensures to complete the "Preadmissions Financial checklist" identifying the person responsible for the resident's finances.
• PIC completes an inspection of the safe records maintained in the NH every 6 months

and a monthly audit maintained by the NH administrator.
• PIC checks resident's money records and audits the records maintained by checking the amount lodged and balances to ensure the records match. This is signed with the NH administrator to certify, confirmed correct.
• As part of the information and reminder to residents in the NH, this is included in the monthly residents' meetings as a rolling agenda.

Implementation of the Falls policy

• All staff members read the policy on "Falls Reduction and Management Policy" increasing awareness and management of residents' post (unwitnessed) falls.
• All nurses and care staff are reminded at daily huddles as part of the "safety pause" to ensure understanding and importance of the required frequency of neurological observations.
• Each resident who falls will have a post falls assessment completed and their care plan updated in accordance with any changes in care needs identified. This will also be checked during care plan audits.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The provider was using external storage on the Centre's grounds to store residents' consumable items such as incontinence wear. However, this storage facility was not included in the centre's floor plans and was not therefore currently registered for use as part of the centre's day-to-day operations. –New floor plans will be developed by the architects to reflect its use. – 30 April 2026.
• The second-floor linen store had changed function to a kitchen store with dried food and crockery being stored - PIC to remove and relocate all the above items and storage facilities reviewed. – 30 May 2026.
• The new open plan communal space on the ground floor had been registered as a dining area but was both operating as a dining and lounge area on the inspection day - The floor plan in the dining room will be amended and a floor plan developed by the architects – 30 April 2026
• Roof leak – Damaged ceiling was repaired and restored. completed 06.02.26
• Inappropriate storage arrangements (hair salon) - PIC to remove and relocate all the above items and storage facilities reviewed. – 30 May 2026.
• PIC checks all mobility aids and equipments used by residents in the home,in conjunction with the Physiotherapist. Equipments checked for wear and tear, PIC ensures residents mobility aids posing a risk to safety and or comfort are removed and replaced.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Builder's materials including door fittings and paint were stored in a boiler room – All the above items were removed and checked by PIC daily. Added as a reminder to all staff members at meetings as a rolling agenda and highlighted at daily huddles. PIC reminds Maintenance to be vigilant of this. – Completed
• Significant containment concerns were noted (doors in the stairwell did not have characteristics of fire doors) – New fire doors installed, stairwell doors replaced - All Fire doors were reviewed and replaced as needed from contractor (Flame Stop). Fire certificate will be issued from contractor. – 30April 2026.
• The comms room on the FF was not effectively separated from the protected escape route due to a passive ventilation grill fitted in the door – This door form part of the fire doors survey being completed by Flame Stop, works had been completed and Fire Cert to follow - 30April 2026.
• Attic hatches on the first floor were not fire- rated and opened into a large attic space that appeared to be used for storage – Attic hatches by Flame stop will be replaced – 30 June 2026
• There was a set of sliding doors which closed off the dining room. These doors did not appear to be fire-rated – The sliding doors were for operational purposes only and not as a containment area – completed
• Fire containment measures – All Fire doors were reviewed and replaced as needed from contractor (Flame Stop). Fire certificate will be issued from contractor. – 30April 2026.

• Floor plans were not installed on walls near the fire alarm panel to help identify the location of the fire – New Fire Evacuation plans have been developed and will be installed when received – 30 April 2026
• Horizontal Evacuation drills are maintained monthly or more often as needed. A Vertical Evacuation drill will commence on foot of a risk assessment (key points to assessing means of escape as per the Fire Safety Handbook) and planning with an external fire safety provider to review and plan most effective routes, lay out and compartmentalisation with the new fire doors installed. This will form part of the Fire Safety and Evacuation training. New Fire Evacuations plans will be developed. 30 May 2026

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: • PIC to ensure that all care plans are developed based on outcome of risk assessments. PIC ensures to inform and communicate to all nursing staff to update care plans if and when resident's condition changes and as per risk assessments outcomes. • PIC to continue to carry out Care plan and assessments audit on a monthly basis to ensure person-centred care plans are developed. – 30 April and ongoing	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	30/07/2026
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.	Substantially Compliant	Yellow	30/07/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Yellow	30/07/2026

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/07/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/07/2026
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	Not Compliant	Orange	30/07/2026

	procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/07/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/04/2026