



**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:	Bushfield Care Centre
Name of provider:	Genesis Healthcare Oranmore Ltd
Address of centre:	Bushfield, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	20 July 2026
Centre ID:	OSV-0005242
Fieldwork ID:	MON-0051084

About the designated centre

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

Bushfield Care Centre is a designated residential care centre for older people operated by Genesis Healthcare Oranmore Ltd. The centre is located in a peaceful rural setting in Bushfield, approximately 2 km from Oranmore Village, County Galway, with convenient access from the N6 motorway. The centre provides 24-hour nursing and personal care for up to 24 adult residents with a range of assessed dependency levels. The service accommodates both male and female residents over the age of 18 years requiring long-term residential care, respite care, convalescent care, dementia care, palliative and end-of-life care, and care for adults with physical disabilities. Bushfield Care Centre is a purpose-designed, single-storey nursing home that promotes accessibility, independence and safety. Accommodation comprises a combination of single and twin bedrooms together with communal dining and sitting rooms, therapy facilities, secure landscaped gardens and outdoor spaces, and a quiet oratory for residents and visitors. Residents are encouraged to personalise their bedrooms and to maintain their independence and lifestyle choices within a homely environment. The service is committed to providing person-centred care that respects the rights, dignity, privacy and individuality of every resident. Care is delivered by a multidisciplinary team of nursing, healthcare, catering, household, maintenance, administration and activities staff, with access to General Practitioner services and a range of allied health professionals. Residents are supported to enjoy a meaningful and fulfilling quality of life through an extensive programme of social, recreational and therapeutic activities tailored to individual interests and abilities. The centre promotes resident choice, autonomy and community engagement, facilitates access to independent advocacy services and religious services, and actively encourages residents to participate in decisions about their care and the running of the centre through regular resident meetings and ongoing consultation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23
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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
Monday 20 July 2026	10:00hrs to 16:30hrs	Sean Ryan	Lead
Monday 20 July 2026	10:00hrs to 16:30hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Inspectors arrived unannounced at the centre and found that the main entrance was closed, with signage directing visitors to an alternative entrance at the side towards the rear of the building.

There was significant construction activity taking place throughout the centre, on the day of inspection. Inspectors observed that a back section of the premises was not in use for residents, and that building works were ongoing in this area. This area was not appropriately closed off to ensure resident safety. Access to the nursing home was unrestricted, and many access doors were observed to be open on arrival to the centre.

Inspectors were met by a clinical nurse manager, to whom the rationale for the inspection was outlined, and shortly afterwards, met with the person in charge.

On arrival, some residents were observed in the dining room, while others were spending time in a conservatory area to the rear of the building or in their bedrooms. Inspectors observed residents receiving their breakfast in the dining room until they were returned to their bedrooms. A lunchtime service was also observed. Meals appeared appetising and nutritious, and residents reported that the food was enjoyable. The dayroom was not in operation on the day of the inspection, to allow for refurbishment. Inspectors observed that this room was used for storage of resident supportive and activity equipment.

Residents who spoke with the inspectors were complimentary about the staff and described them as kind and caring. However, residents described how the ongoing construction works were impacting on their daily lives in the centre. Some residents had moved bedrooms to facilitate the works, and from discussions with residents, it was clear that they had not been offered a choice regarding these moves. While residents said they looked forward to seeing the centre when works were completed, they described the current environment as difficult due to noise, disruption and movement of construction personnel throughout the centre. Some residents said that they had the opportunity to raise their concerns at residents' meetings; however, they did not consider that this had resulted in an improvement in their experience during the works.

Inspectors observed accumulations of construction dust and debris on floors and surfaces throughout the centre. In catering areas, construction dust was observed on stored food items, including fresh fruit and vegetables.

Residents acknowledged that staff did their best to keep them engaged and supported during this period. One resident told the inspectors that they preferred to remain in their bedroom due to the increased activity and disruption in communal areas. Other residents described spending much of their time in either the dining

room or the conservatory, which was being used as an alternative day room while works were ongoing.

A number of fire safety risks were observed during the walk-through of the centre. Doors were held open with wheelchairs and make-shift wedges, including cross-corridor fire doors outside the kitchen area. Fire detection has been disconnected at the temporary entrance to the centre and attic hatches were observed to be left open. This could compromise fire containment measures in the event of a fire emergency. Combustible materials, including cardboard and empty bottles, were found stored in an electrical switch room. This was a repeated observation from a previous inspection.

In areas where refurbishment and redecoration had been completed, inspectors observed that these had been finished to a high standard, including residents' bedrooms. However, inspectors also observed changes to the layout and configuration of the premises that were not aligned to the floor plan for which the centre is registered. New bedrooms had been constructed from previous rooms in the centre, and the dimensions and configurations of some existing shared bedrooms had changed, with some reduced in size. A bedroom had also been converted for use as a temporary laundry. This posed a potential fire safety risk in the centre. In sections of the centre, floor coverings had been removed and the underlying concrete floor was exposed.

Residents spoke positively about opportunities to go on outings from the centre. However, a number of residents and visitors expressed dissatisfaction with the quality and range of activities available to them and said that the activities provided did not always reflect their individual interests or abilities. Some residents spoke about particular activities they enjoyed, but said that these activities were not provided to them. On the day of inspection, a guest speaker attended the centre to speak to residents, however no other organised activities were observed taking place, as an alternative.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability of the provider to deliver a safe and effective service, and how the arrangements in place impact on the quality and safety of the service provided 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), with a particular focus on fire safety and premises. Inspectors also followed up on the progress of

actions taken by the provider to address issues of non-compliance found on the last inspection in April 2026.

Inspectors followed up on unsolicited information received by the Chief Inspector. The concerns related to the oversight and management of premises and fire safety works being undertaken in the centre, including the day-to-day management of these works and their impact on residents, as well as aspects of the quality of care provided to residents. This information was substantiated on this inspection.

The findings of this inspection identified significant deficits in the governance and management of Bushfield Care Centre. While the provider had undertaken extensive fire safety remediation works, the ongoing construction project was not managed in a manner that ensured the continued safety and welfare of residents. Effective governance, oversight and risk management systems were not in place to identify, assess and mitigate the risks associated with the construction works, including risks relating to fire safety, and infection prevention and control. This impacted on residents' safety and quality of life in the centre. In addition, the provider had made changes to the layout and use of areas within the designated centre which were not consistent with the statement of purpose and registered floor plans, resulting in a breach of Condition 1 of the centre's registration. As a result of the risks associated with the findings identified during this inspection, an urgent compliance plan request was issued to the registered provider, and an urgent warning meeting was held. At this meeting, the registered provider was advised that continued non-compliance with the regulations could result in the cancellation of the registration of the designated centre.

A previous inspection in April 2026 found that the registered provider had failed to progress and complete the required fire safety and premises works in accordance with a project plan submitted to the Chief Inspector and, as a result, had breached Condition 4 and 5 attached to the registration of the centre. Inspectors also found that there was poor governance and oversight of the ongoing fire and premises works, including inadequate monitoring of completed and outstanding works and the impact of these works on resident safety. As a result, the provider was issued with an urgent compliance plan request and required to attend a cautionary meeting. The provider subsequently applied to vary the conditions of registration, and a revised compliance date of 31 August 2026 was approved for completion of the works.

Genesis Healthcare Oranmore Limited is the registered provider of this designated centre and was first registered by the Chief Inspector in February 2026. It is a company comprised of a board of three directors, who are involved in the operation of other designated centres for older persons. The registered provider was represented by one director in engagement with the Chief Inspector.

The organisational structure supporting the designated centre had changed since the previous inspection. Governance of the service was provided by a board of directors, with operational oversight delegated to the operations manager, who was also a person participating in the management of the centre. Since the previous inspection, the provider had also appointed a clinical governance, risk and compliance lead to support clinical oversight and support the provider's governance

arrangements. Within the centre, a person in charge was supported by an assistant director of nursing and a clinical nurse manager.

Inspectors found that the governance and management arrangements for the ongoing construction works remained ineffective. There was no effective project management framework. Risks to residents regarding fire safety, premises and infection prevention and control were not adequately managed, and overall accountability for the planning, implementation and oversight of the works remained unclear. Inspectors also identified emerging deficits in the oversight and monitoring of residents' care, particularly in relation to nutritional needs and the management of residents with infection.

Since the previous inspection, the provider had established a risk management framework, underpinned by a risk management policy and procedure and supported by a risk register. However, these arrangements were not effectively implemented in practice. For example, a risk assessment for the construction works identified that controls to manage dust and protect residents, including the use of dust barriers and enhanced cleaning, but these measures were not in place and there was no clear accountability for monitoring their implementation. In addition, high-risk services, including the laundry, had been temporarily relocated to a vacant bedroom to facilitate the construction of catering facilities, without an appropriate assessment of the associated fire safety and infection prevention and control risks.

The provider had not put appropriate arrangements in place to ensure that residents' records remained secure, accessible and readily retrievable during construction works. Confidential records were being stored in an unsecured area, demonstrating inadequate planning and oversight of records management.

The organisation and management of the staffing resources were not effective. Staff responsibilities in relation to enhanced environmental cleaning and infection prevention and control measures had not been clearly defined or communicated. Inspectors found that staff were unclear regarding the additional cleaning arrangements required in response to construction works and the respective responsibilities of the centre staff and contractors. This lack of clarity resulted in appropriate environmental cleaning and infection prevention and control measures not being consistently implemented throughout the centre.

Following the previous inspection, the provider had ensured that staff completed additional training fire safety, fire prevention and safeguarding of vulnerable people. Staff spoken with during the inspection demonstrated an appropriate knowledge of these areas and described procedures to be followed in the event of a fire or safeguarding concern.

While management structures were in place to supervise staff through the presence of nurse managers, supervision arrangements were not effective. This was evidenced by repeated poor fire safety practices, deficits in environmental hygiene, and a failure to consistently deliver care to residents in line with their assessed needs.

While action had been taken in relation to the documentation and investigation of complaints since the previous inspection, inspectors found that the systems for recognising complaints remained ineffective. Inspectors found that feedback from residents regarding the quality of the service, including the impact of ongoing construction works and the quality of food provided, was not consistently recognised as expressions of dissatisfaction about the service. Consequently, these matters were not always managed through the provider's complaints management systems.

Regulation 16: Training and staff development

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of residents. This was evidenced by the registered provider's failure to;

- Provide an appropriate level of staff supervision, monitoring and support to ensure that the health and social care needs of all residents were consistently met in a timely manner, and to ensure that the recommendations of allied health care professionals were implemented.
- Supervise the delivery of care to residents, in line with their assessed needs and care plans. For example, a resident at risk of malnutrition and who had experienced significant weight-loss, were not provided with nutritional care in line with their care plans.
- Adequately supervise staff to ensure an appropriate standard of environmental hygiene was maintained to protect residents from the risk of infection.
- Ensure appropriate supervision of staff to implement and maintain fire safety precautions and control measures to protect residents from the risk of fire.

Judgment: Not compliant

Regulation 21: Records

A review of the management of records found that records were not in line with the requirements of the regulations. For example;

- Records were not maintained in a manner that was safe. Residents' nursing and medical records were stored in an unsecured location on a corridor. This created a risk of unauthorised access to confidential records.
- Records did not demonstrate that residents had received care in accordance with their assessed needs and care plans, or that appropriate interventions were implemented as required. For example, weight monitoring records were incomplete for some residents and refusal of care was not appropriately documented.

- Records were not maintained in a manner that was organised, accessible or readily available for review. Records to demonstrate governance and management of the service and fire safety were not all made available for inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had altered a number of areas within the designated centre. These alterations were not consistent with the statement of purpose and registered floor plans. As a result, the registered provider had breached Condition 1 of registration.

Lines of accountability and responsibility within the management structure were not clearly defined, including responsibility for key areas of risk management, fire safety, infection prevention and control, and the premises. This resulted in ineffective oversight and management of significant risks within the centre. In particular, there was inadequate oversight of the ongoing fire safety and premises works and the associated risks to residents. Due to the significant risk to residents' safety and welfare, an urgent compliance plan was requested from the provider in relation to governance and management. The response received outlined the arrangements being implemented by the provider to ensure effective oversight of the ongoing works, including clearly defined lines of accountability and responsibility and the management of associated risks. This response was accepted by the Chief Inspector.

A poorly defined organisational structure continued to impact on the management systems in place to ensure that the service provided was safe, consistent and appropriately monitored. This was evidenced by'

- Ineffective oversight of risk management systems to identify, monitor and manage known risks with the potential to impact the safety and welfare of residents living in the centre.
- Poor oversight of infection prevention and control arrangements to ensure that residents were protected from the risk of infection associated with the ongoing construction works.
- Ineffective monitoring of residents' clinical care needs, including nutritional care, was not effective to ensure that identified needs were appropriately assessed, monitored and responded to.
- Ineffective management of complaints, with repeated findings that expressions of dissatisfaction or concerns raised by residents were not consistently recognised or managed in line with the centre's complaints policy and procedure.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were not always recorded and managed in line with the centre's own policy and the requirements of the regulation.

Complaints and expressions of dissatisfaction by residents in relation to food quality and ongoing construction works during resident meetings were not documented, investigated as complaints, or responded to, in line with the provider's complaints policy and procedure.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

The quality and safety of the service provided to residents was impacted by ineffective governance, oversight and risk management arrangements described in the capacity and capability section of this report. Significant risks were identified in relation to fire safety and infection prevention and control. Inspectors also found deficits in the monitoring and review of some residents' assessed care needs, including the implementation of recommendations made by health care professionals. Residents' rights and choice were also impacted by the ongoing construction works and the provision of activities in the centre did not always meet the needs of residents.

The provider was progressing a significant programme of fire safety remediation works since the previous inspection. However, inspectors found that the management and oversight of fire safety during ongoing construction works remained ineffective. Fire safety precautions, in place to protect residents while works were in progress, were not consistently implemented or monitored, and inspectors found repeated poor fire safety practices that compromised fire containment and evacuation arrangements. The risk identified were indicative of a lack of monitoring, management oversight, and effective governance arrangements in relation to fire safety practices within the centre, resulting in an urgent compliance plan request being issued to the provider following this inspection.

Inspectors found that the provider had not ensured effective infection prevention and control arrangements during ongoing construction works. The systems in place to identify, assess and manage infection risks to residents were not effective, and inspectors found that a number of control measures identified by the provider had not been implemented or monitored. As a result, construction works were not being managed in a manner that minimised the risk of environmental contamination and healthcare-associated infection to residents. Consequently, an urgent compliance plan request was issued to the provider following this inspection.

The premises was not maintained in a manner that promoted a safe, comfortable and suitable living environment for residents. Temporary changes to the layout and use of rooms, together with deficits in environmental hygiene and the management of the premises, resulted in areas of the centre that were not appropriate to meet residents' needs or to support the safe delivery of care. In addition, alterations to the layout of residents accommodation and ancillary facilities had resulted in area of the centre no longer being used for in their intended purpose and function, in line with the statement of purpose.

Residents assessments and care plans were reviewed during the inspection. While residents' care needs had generally been assessed and care plans were in place, inspectors found that the systems for reviewing and updating care documentation were not consistently effective. As a result, some residents' changing needs were not always appropriately assessed and care plans were not consistently updated to provide person-centred guidance to staff. This was evident in relation to the management of residents' nutritional needs and infection.

On the day of the inspection, due to the ongoing building works, the kitchen was not used to prepare residents main meal. Meals were being temporarily out-sourced from a local catering company. While residents' feedback in relation to the quality of the food was generally positive, meals did not fully cater for the nutritional requirements of the residents.

Residents had access to general practitioner services and were referred to appropriate health and social care professionals, as required. However, inspectors found that the monitoring and review of some residents' health care needs was not consistently effective. This resulted in recommendations made by health care professionals not always being fully implemented or evaluated to ensure they achieved the intended outcome for residents.

Inspectors found that residents' rights were not fully upheld. Opportunities for meaningful occupation and recreation did not always reflect residents individual interests, preferences and assessed needs. Residents reported that they did not always feel fully consulted or supported to exercise choice in relation to changes affecting their living arrangements, including changes to their accommodation.

Regulation 17: Premises

The registered provider failed to ensure that the premises of the designated centre was maintained in accordance with the statement of purpose. The size and layout of a number of bedrooms had been altered and no longer corresponded with the registered floor plan. In addition, a bedroom had been repurposed for use as a temporary laundry facility.

While premises works were progressing in line with a condition of registration for completion by 31 August 2026, the premises did not meet the requirements of Regulation 17 at the time of this inspection. For example;

- The management of storage areas within the centre was poor. Equipment used by residents was stored along corridors and in vacant bedrooms.
- Floor coverings were absent from some corridors that were accessible to residents.

Judgment: Not compliant

Regulation 18: Food and nutrition

There was a failure to deliver food and nutrition to residents in line with regulatory requirements. This was evidenced by;

- The food provided to residents did not consistently meet their individual dietary needs as prescribed by health-care professionals. The external supply of the lunchtime meal did not ensure that residents' prescribed dietary requirements were consistently met, including high -protein, high-calorie, high-fibre and low-sodium diets.
- Arrangements did not ensure that food was stored or prepared safely, as food storage areas were exposed to dust arising from works within the centre.
- Residents who had been assessed by health professionals as requiring therapeutic diets or nutritional supplementation to support the management of their weight did not always receive these in accordance with the recommendations made. For example, a resident had been reviewed by a dietitian in May 2026. However, the recommended nutritional plan had not been implemented. A review of a resident's weight records found that the resident had continued to lose weight.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not meet the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018).

- Appropriate oversight and precautions were not in place to minimise the spread of dust and environmental contamination from areas where construction works were taking place.
- Environmental cleaning was not sufficient to maintain the centre to an appropriate standard of hygiene. Enhanced cleaning was not being undertaken in areas affected by construction dust.
- Appropriate infection prevention and control precautions were not implemented when areas of the centre were repurposed, including the relocation of ancillary facilities to areas not designed or equipped for that purpose.

As a consequence of these concerns, an urgent compliance plan was requested from the registered provider. The response received provided assurance that actions had been taken to manage and address the identified infection prevention and control risks.

Judgment: Not compliant

Regulation 28: Fire precautions

There continued to be significant deficits in the monitoring, management and oversight of fire safety practices and identified fire risks within the centre. As a result, an urgent compliance plan request was issued to the registered provider to address risks relating to compromised fire containment measures, the failure to implement identified risk control measures, and deficits in fire evacuation arrangements. The response received provided assurance that actions were being taken to manage and address the identified fire safety risks.

The following findings identified during the inspection demonstrated significant and repeated deficits in fire safety arrangements within the centre.

- Arrangements to review fire precautions were not effective. Fire safety checks were not appropriately completed and failed to identify significant risks that compromised measures for the containment of fire.
- Adequate arrangements were not in place for containing fire. Inspectors observed attic hatches left open, fire doors wedged open, and a number of fire doors that did not close effectively, thereby compromising fire containment measures.
- Flammable items such as cardboard boxes, plastics and electrical equipment continued to be stored in an electrical plant room. An immediate action was issued on the day of inspection requiring removal of these items.

- Fire evacuation plans had not been updated following changes to the layout of the centre and function of rooms, and consequently did not clearly direct staff to appropriate evacuation routes. In some instances, evacuation plans directed staff to evacuate residents through exits in areas of construction activities that were not accessible.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Residents did not always have a comprehensive and accurate assessment of their needs completed to inform their care. A resident's nutritional needs had not been appropriately reassessed following a change in their clinical condition. Following an improvement in a resident's clinical condition, their nutritional needs were not reassessed despite continued weight-loss, and the care plan was not updated to reflect their current needs or the effectiveness of existing interventions.
- Care plans, for residents with infection, had not been updated to provide adequate information to guide infection prevention and control measures during care delivery. Consequently, not all staff had awareness of residents' infection status and individual needs.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' choices were not always fully respected. Residents described having to move bedrooms to facilitate construction works, and the restrictions associated with these works limited residents' choice regarding where they could spend their day.

Not all residents were provided with opportunities to participate in activities that met their individual needs, capacities and interests. A review of activity records identified periods of up to seven days where there was no documented evidence of residents participating in activities. This was consistent with feedback received from residents and the inspectors' observations on the day of inspection.

Judgment: Not compliant

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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 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Bushfield Care Centre OSV-0005242

Inspection ID: MON-0051084

Date of inspection: 20/07/2026

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
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The provider accepts that supervision arrangements at the time of inspection were not effective, as shown by repeated poor fire safety practice, deficits in environmental hygiene and care not delivered in line with assessed needs.</p> <p>Actions taken</p> <ul style="list-style-type: none">• From 24 July 2026, the nurse manager on duty verifies on every shift that care for residents with identified nutritional, infection prevention and control (IPC) or other clinical risks has been delivered in line with their assessed needs and care plans. Omissions are escalated and addressed on the same shift. This verification is recorded in the end of shift report and these are reviewed weekly by the Person in Charge.• From 24 July 2026, environmental hygiene responsibilities were allocated in writing between centre staff and the construction contractor, with visible-dust checks at least twice daily verified by the nurse manager on duty.• From 24 July 2026, a documented fire safety check has been completed on every shift by the nurse in charge, covering fire doors, attic hatches, escape routes, fire detection status, storage and housekeeping on protected routes.• Since 22nd September 2026 the Person in Charge has carried out unannounced on-the-floor knowledge checks with staff on four topics: fire safety and evacuation; recording the resident's voice; how to escalate concerns and incidents; and recognising and recording complaints. A minimum of 10 staff are checked each week across day, night and weekend shifts and all roles, and each check is recorded. A staff member who cannot demonstrate the required knowledge is coached immediately and rechecked within seven days.• Since 17th September 2026 the Head of Operations, Older Persons Services or the Clinical Governance, Risk and Compliance Lead has recorded their weekly visits on the Senior Site Visit record (GHI-F-GOV-01). The visit tests on the floor what supervision records say, including fire doors, storage, hygiene and care delivery. Anything found is entered on the Open Items Register at Part C of this document and is carried forward to	

the weekly check of the following week.

- The Genesis Management Handbook is being launched on 29th September 2026. Its frameworks are introduced to the Person in Charge one framework at a time and cascaded to staff through the centre governance meeting, so that each is understood and in use before the next is introduced. The first framework for introduction is the B5 Integrated KPI, Governance and Assurance Framework on 29th September 2026.

Monitoring

- Shift verification records, fire safety checks, hygiene checks and knowledge-check results are reviewed weekly by the Person in Charge and monthly at the centre's Quality and Safety Committee (GHI-TOR-QSC). A gap is closed only when a second person has verified that the improvement has held.

Responsible

Person in Charge, supported by the Assistant Director of Nursing, and the Clinical Nurse Manager. Provider oversight: Head of Operations, Older Persons Services.

Compliance date

30 September 2026.

Regulation 21: Records

Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

The provider accepts the findings.

Actions taken

- Regulation 21(6): on 20th July 2026, residents' nursing and medical records were removed from the unsecured corridor location to the nurses' station, which is secured by keypad and accessible to authorised staff and inspectors. This action is complete. Under the Works in Operating Centres Governance Suite, the secure location of records must be planned and confirmed before any future works affect the area where records are held.
- Regulation 21(1): since 23rd July 2026, the Person in Charge or delegate has completed a weekly sample audit of records covering weight monitoring, refusal of care, nutritional interventions and infection-related care. Each omission is assigned to a named nurse, entered on the Open Items Register and tracked to closure.
- Governance, works, fire safety and IPC records are held in an indexed governance file at the centre's reception desk, so that they can be produced promptly for management review and inspection. The Person in Charge confirms monthly, at the Quality and Safety Committee, that the index is complete and current.

Monitoring

- Records audit results are reported monthly to the Quality and Safety Committee and reviewed at the weekly senior site visit.

Responsible

Person in Charge.

Compliance date

Regulation 21(6): completed 20th July 2026. Regulation 21(1): 30 September 2026.

Regulation 23: Governance and management

Not Compliant

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

The registered provider accepts the findings in full, including that this is a repeated non-compliance.

1. Alterations to the centre: preventing recurrence (Condition 1)

The provider fully acknowledges that any structural change to the footprint of a registered centre requires prior consultation with, and approval by, the Chief Inspector. The same applies to any change to the size, layout or use of a registered area. The controls below make that a fixed requirement of how Genesis operates.

- The Material Change Decision Protocol (GHI-WOC-01) was brought into operation on 16th September 2026. Before any change to the size, layout, configuration or use of any room or area is started, the change must be assessed under this protocol to decide whether it requires an application to vary the conditions of registration, a notification to the Chief Inspector, or an internal record only. The decision is recorded, signed by the Clinical Governance, Risk and Compliance Lead and approved by the Chief Executive Officer before any work begins.
- Where an application to vary is required, no alteration will start until the application has been submitted to the Chief Inspector, and no altered area will be brought into use until the variation has been granted and the Statement of Purpose and floor plans have been updated. If an alteration is found to have started without this, work on that area stops until the correct regulatory route has been completed.
- Any temporary change of use during works, such as relocating a service into a bedroom, is treated as a change under the protocol. It requires a prior fire safety, IPC and resident-impact risk assessment and is raised with the Chief Inspector before it is implemented.
- The Commissioning, Handback and Registration-Readiness Protocol (GHI-WOC-10) prevents any new or altered area from being brought into use until it is confirmed to be within the registered floor plans and Statement of Purpose. The Notifications and Regulatory Liaison Protocol (GHI-WOC-11) sets out what must be notified to the Chief Inspector and when, and keeps a log of all engagement with the Chief Inspector.
- A register of every material change decision for the centre is reviewed at each Weekly Works Governance Meeting while works are active and at the monthly Quality and Safety Committee thereafter. It is reported to the Board through the Group Assurance Report.

2. Management structure and lines of accountability — Regulation 23(1)(b)

The management structure is: Board of Directors of the registered provider; Chief Executive Officer; Head of Operations, Older Persons Services; Person in Charge;

Assistant Director of Nursing and Clinical Nurse Manager; nurse in charge of each shift. The Clinical Governance, Risk and Compliance Lead reports to the Chief Executive Officer and provides independent assurance. Responsibility for each key area is as follows:

- Risk management: the Person in Charge owns the centre risk register and the Open Items Register. The Clinical Governance, Risk and Compliance Lead owns the risk management framework and verifies that risk controls are in place and working.
- Fire safety: the Person in Charge is accountable for fire safety practice in the centre, including the shift fire safety checks, staff fire training, drills and evacuation plans. The Company Director is accountable for the fire safety works and their certification by an external service provider.
- Infection prevention and control: the Person in Charge is accountable for IPC practice. The Clinical Governance, Risk and Compliance Lead provides provider-level oversight, with the external IPC specialist advising during works.
- Premises: the Company Director is accountable for the works programme, the contractor interface and the Building Method Statement. The Person in Charge is accountable for the day-to-day use, condition and storage arrangements of the premises. The Chief Executive Officer approves every material change decision and every application to vary. For all future projects of this type, a dedicated Project Manager will support the works, as set out above.
- Residents' clinical care, including nutrition: the Person in Charge, supported by the Assistant Director of Nursing.
- Complaints and the resident's voice: the Person in Charge, as Complaints Officer, with the nurse in charge of each shift responsible for recording concerns raised at handover.
- Operational oversight: the Head of Operations, Older Persons Services (the named PPIM) line-manages the Person in Charge and holds the provider's operational oversight of the centre.
- These roles are set out in Construction Governance Roles, Responsibilities and Terms of Reference (GHI-WOC-08) for works, and in the B5 Integrated KPI, Governance and Assurance Framework for ongoing operations.

3. Management systems — Regulation 23(1)(d)

The provider's group governance system, the B5 Integrated KPI, Governance and Assurance Framework (v4.1), is being launched at the next PIC Meeting on 29th September. It works on one loop: find the gap; fix it, with a named owner and a calendar date; and verify, by a second person, that the fix has held before the gap is closed. It runs to a fixed rhythm:

- Daily: one Open Items Register per centre (GHI-RSA-02) holds every gap from every source (inspection findings, audits, incidents, complaints, knowledge checks and site visits) until its closure is verified. All findings in this report have been entered on it. Statutory notifications are made within the required timeframes, and timeliness is tracked across the group.
- Weekly: a senior site visit by the Head of Operations or the Clinical Governance Lead (GHI-F-GOV-01) checks on the floor what the records say. The Person in Charge reviews the site KPI's (A group wide dashboard is under construction currently and will be operational by end December 2026). The Chief Executive Officer chairs a weekly executive governance meeting at which every Red item across the group is tracked until it is Green. The Weekly Works Governance Meeting continues until final handover of the works.
- Monthly: the centre's Quality and Safety Committee (GHI-TOR-QSC), chaired by the

Person in Charge and attended by the Head of Operations and/or Clinical Governance Lead, reviews risk, incidents, complaints and residents' feedback, IPC, fire safety, nutrition and weight monitoring, care plan audits and knowledge-check results. The centre's figures are submitted once (GHI-RS-01) and used unchanged in the Operations and Clinical Governance reports to the Chief Executive Officer and the Board.

- Quarterly and annually: nursing leadership re-checks every open gap against the regulation and closes only what has held. The Board receives the governance KPI's and every Red item. A full self-assessment against every regulation, and the annual review of quality and safety, are completed each year, at year end.
- The Genesis Management Handbook is being launched on 29th September and is being introduced one framework at a time: first to the Person in Charge, then cascaded through the centre governance meeting.
- The Works in Operating Centres Governance Suite (GHI-WOC-00 to GHI-WOC-11) was adopted on 17th September 2026. It turns the arrangements put in place at this centre after the inspection into controlled standards for any future works in an occupied Genesis centre: the Building Method Statement, phasing, interim fire safety and evacuation, IPC during works, resident and family engagement and consent, risk, permit-to-work, commissioning and handback, and notifications.
- Oversight of residents' clinical care and of complaints is described under Regulations 5, 18 and 34 and forms part of the monthly Quality and Safety Committee and the weekly senior site visit.

Responsible

Chief Executive Officer, on behalf of the registered provider, with the Head of Operations, Older Persons Services, and the Clinical Governance, Risk and Compliance Lead.

Compliance date

The immediate works governance arrangements for Bushfield were in place from 22 July 2026 (Regulation 23(1)(b)) and 23 July 2026 (Regulation 23(1)(d)). The management structure and systems set out above are in place at the date of this submission (except the Management Handbook being launched on 29th September), and communication of lines of accountability to all staff will be completed by 30 September 2026. The provider will verify that these arrangements have held through the first quarterly self-assessment review at the centre, to be completed by 31st October 2026.

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

Regulation 34: Complaints procedure	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <p>The provider accepts that this is a repeated non-compliance and that staff did not consistently recognise and record residents' expressions of dissatisfaction as complaints.</p> <p>Actions taken</p> <ul style="list-style-type: none"> • From 17 September 2026, the resident's voice, including any concern, dissatisfaction or complaint expressed by a resident or representative, is a standing item at every clinical 	

<p>handover. The nurse in charge records concerns raised and ensures they are entered on the complaints register where appropriate.</p> <ul style="list-style-type: none"> • From 17 September 2026, complaints and residents' feedback are a standing item at the centre governance meeting. New complaints, expressions of dissatisfaction, actions, outstanding actions and feedback to the resident or representative are tracked to closure. • The Person in Charge and the Activities Co-ordinator review the minutes of every residents' meeting to identify any concern that should be entered on the complaints register. • By 30 September 2026, the Person in Charge will review the minutes of all residents' meetings held since February 2026 and enter on the complaints register any expression of dissatisfaction that was not recorded at the time, with a response to the residents concerned. • Targeted training on Regulatory Compliance, including recognising complaints, recording the resident's voice in the resident's own words, escalation, investigation and closing the feedback loop was delivered by the CEO on 22nd September, and this presentation will be repeated by the PIC over the coming weeks until all staff have attended a session.(Completion date 30 September 2026). Attendance is recorded and understanding is checked through scenario-based assessment. • Recognising and recording complaints is one of the four topics in the Person in Charge's on-the-floor knowledge checks with staff (see Regulation 16). <p>Monitoring</p> <ul style="list-style-type: none"> • The Person in Charge completes a weekly complaints audit for four weeks, to 23rd October 2026, and monthly thereafter. Results are reviewed at the Quality and Safety Committee. Because this is a repeated finding, the Clinical Governance, Risk and Compliance Lead will independently verify at the first quarterly self-assessment review, by 31st October 2026, that the improvement has held before the item is closed on the Open Items Register. <p>Responsible Person in Charge. Independent verification: Clinical Governance, Risk and Compliance Lead.</p> <p>Compliance date 30 September 2026.</p>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises: The provider accepts the findings in full. At the inspection on 20 July 2026, the size, configuration and use of a number of areas did not match the registered floor plan and Statement of Purpose, in breach of Condition 1 of registration; storage was poorly managed; and floor coverings were missing from corridors accessible to residents. Alterations to the premises: current position and preventing recurrence</p>	

- The works programme reached completion on 22nd September 2026. On 25th September 2026, on receipt of the Fire Certificate, the provider will apply to vary the conditions of registration to reflect the completed premises, with revised floor plans and Statement of Purpose. Until the Chief Inspector's decision, no area is used for a purpose other than that for which it is registered.
- The temporary laundry was removed from bedroom 23 on 31st July 2026 when laundry was outsourced to an external service provider. The outsourcing of the laundry function remains in place until an application to vary the registration of the newly constructed external laundry building has been submitted to the Chief Inspector and a decision has been issued.
- The provider fully acknowledges that any structural change to the footprint of a registered centre requires prior consultation with, and approval by, the Chief Inspector. It also acknowledges that works of the magnitude undertaken at Bushfield required a dedicated Project Manager; one will be in place for all future projects of this type (see Regulation 23).
- To prevent recurrence, any future change to the size, layout or use of any area must first be assessed under the Material Change Decision Protocol (GHI-WOC-01). No alteration will start until any required application to vary has been submitted to the Chief Inspector, and no altered area will be used until the variation is granted. This is set out in full under Regulation 23.

Floor coverings

- Floor coverings were removed from corridors where there was significant wear and tear in phases ahead of replacement, and this was completed by 22nd September 2026.
- No area with exposed or unfinished floors will be accessible to residents in any future works. Such areas are kept within the sealed works zone until finishes are complete and signed off by the contractor, the Person in Charge and the provider.

Storage

- Corridors, vacant bedrooms and communal rooms are not used for storage. An audit of surplus and unused equipment will be completed by 2nd October 2026, and removed from the centre by the 5th October 2026.
- The nurse in charge checks storage every shift as part of the shift safety check, and the weekly senior site visit (GHI-F-GOV-01) checks it again. Any breach is corrected at the time and recorded on the Open Items Register.

Final handover

- Before final handover of the works, all doors in the centre, including all fire doors, were audited and any defects rectified. This was completed on 23rd September 2026.

Responsible

Company Director, (works, floor coverings and final handover); Person in Charge (use of rooms and storage); Chief Executive Officer (application to vary).

Compliance date

22nd September 2026 for floor coverings and 5th October 2026 for storage. Full compliance with Regulation 17(1) and 17(2) on the Chief Inspector's decision on the application to vary of 25th September 2026.

Regulation 18: Food and nutrition	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 18: Food and nutrition:</p> <p>The provider accepts the findings.</p> <p>Actions taken</p> <ul style="list-style-type: none"> • Meal preparation returned to the centre's kitchen on 31 August 2026 and the temporary external supply of main meals ended. A current dietary requirements report, showing prescribed therapeutic diets and supplements, is available to clinical and catering staff and is updated whenever a resident's needs change. • Following the inspection, every resident at risk of malnutrition or unplanned weight loss had their nutritional assessment, weight history, dietetic recommendations and care plan reviewed. This review was completed on 23rd July 2026, and repeated on 19th September 2026. Outstanding recommendations were implemented or re-referred. • A named nutrition lead nurse oversees nutritional care and the implementation of dietetic recommendations. • Food storage areas were protected from construction dust and enhanced cleaning introduced following the inspection. The kitchen has operated in its completed form since 31st August 2026. The new wash-up area was fully completed on 21st September 2026. <p>Monitoring</p> <ul style="list-style-type: none"> • Weights and nutrition records are reviewed weekly by the Person in Charge or delegate, with any unplanned weight loss or unimplemented recommendation entered on the Open Items Register. Nutrition and weight indicators are reported monthly to the Quality and Safety Committee. <p>Responsible</p> <p>Person in Charge, with the nutrition lead nurse.</p> <p>Compliance date</p> <p>21st September 2026.</p>	
Regulation 27: Infection control	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <p>The provider accepts the findings.</p> <p>Actions taken</p> <ul style="list-style-type: none"> • On 21 July 2026 the provider appointed an external IPC specialist to review construction-related IPC risk and to provide ongoing advice. An on-site assessment on 24th July 2026 addressed dust, Aspergillus, air quality and water safety, and its recommendations were built into construction controls. • From 24th July 2026, controls included sealed containment between works and resident areas, dust extraction and suppression, controlled contractor routes, sealed 	

waste removal and additional air management where indicated by risk assessment.

- From 24 July 2026, cleaning responsibilities were set out in writing: the contractor completes builder's cleans; centre household staff complete enhanced cleaning in resident areas next to works, with visible-dust checks at least twice daily verified by the nurse manager. External specialist deep cleaning was introduced.
- Individual construction-related risk assessments were completed for residents at increased risk. The room handback process requires IPC confirmation of containment removal, deep cleaning and fitness for use before any area is returned to residents.
- Now that the works have been completed the external IPC specialist will complete a post-works review of the centre Monday 28th September 2026.
- For any future works in an occupied Genesis centre, the IPC Governance Protocol during Building Works (GHI-WOC-05) requires an infection control risk assessment for each phase before work starts.

Monitoring

- IPC controls are reviewed at each Weekly Works Governance Meeting until final handover, and IPC audit results are reported monthly to the Quality and Safety Committee.

Responsible

Person in Charge (IPC practice). Provider oversight: Clinical Governance, Risk and Compliance Lead.

Compliance date

Controls in place from 24 July 2026. Post-works IPC review completed 28th September 2026.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions: The provider accepts that fire safety is a repeated non-compliance and that its controls must be specific, demonstrable and sustained.

Actions taken

- From 24 July 2026, the nurse in charge has completed a documented fire safety check on every shift covering fire door closure, attic hatches, escape routes, fire detection status and housekeeping on protected routes. Deficits are corrected immediately, recorded and escalated.
- From 24 July 2026, attic hatches must remain closed when not in active use; fire doors must not be wedged or held open unless fitted with an approved hold-open device; and combustible materials are prohibited from electrical and plant rooms. These rules form part of staff supervision and contractor induction and are checked every shift.
- Fire detection and alarm cover is maintained during works through a controlled, time-limited impairment process with documented compensating controls, including fire watch where required, and reinstatement and testing before the end of the working day.
- Temporary breaches of fire-rated construction are fire-stopped or protected by an approved temporary measure before the end of each working day. Completed fire safety

<p>works are certified by a competent person before handback.</p> <ul style="list-style-type: none"> • Before final handover was accepted, every door in the centre, including all fire doors, was audited for condition, operation, closing, gaps, seals, ironmongery and fire rating, and all defects rectified. The audit was completed on 23rd September 2026. • Fire safety is a standing item at the Weekly Works Governance Meeting, is checked at every weekly senior site visit, and is one of the four topics in the Person in Charge's on-the-floor knowledge checks with staff. • For any future works, the Interim Fire Safety and Evacuation Protocol (GHI-WOC-04) and the Permit-to-Work and Hot Works Protocol (GHI-WOC-09) set the controls that must be in place before work begins. <p>Responsible Person in Charge (fire safety practice, checks, drills and evacuation plans). Company Director (fire safety works, door audit and certification).</p> <p>Compliance date Regulation 28(1)(c)(ii) and 28(2)(ii): in place from 24 July 2026. Regulation 28(1)(a) and 28(2)(i): by 23rd September 2026 on completion of the door audit, competent-person certification and the drill for the completed layout. The provider can confirm that the date of 22 September 2026 for Regulation 28(1)(a) and 28(2)(i) was met.</p>	
Regulation 5: Individual assessment and care plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: The provider accepts the findings.</p> <p>Actions taken</p> <ul style="list-style-type: none"> • A focused review of the assessments and care plans of all residents whose condition had changed, including residents with weight loss, nutritional risk or infection, was on 23rd July 2026. • Assessments and care plans are updated when a resident's condition changes and are not deferred to the next four-monthly review. Care plans for residents with infection state the infection status, required precautions, monitoring and escalation. • Dietetic and other allied health recommendations are entered in the care plan, and their implementation and effectiveness are evaluated at each review. <p>Monitoring</p> <ul style="list-style-type: none"> • The Person in Charge or delegate completes a weekly sample audit of care plans. Omissions are assigned to a named nurse, entered on the Open Items Register and tracked to closure. Results are reported monthly to the Quality and Safety Committee. <p>Responsible Person in Charge, with the Assistant Director of Nursing.</p> <p>Compliance date 30 September 2026.</p>	

Regulation 9: Residents' rights	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights: The provider accepts this finding. Residents told inspectors that they had not been offered a choice about moving bedroom and did not feel fully consulted about changes to their home. The residents' experience is the measure: the provider's arrangements did not give residents a real choice or a sufficient say. The provider also accepts that activities did not meet residents' individual needs and interests.</p> <p>Choice about accommodation — Regulation 9(3)(a)</p> <ul style="list-style-type: none"> • By 30 September 2026, the Person in Charge will meet each resident who moved room during the works, with their representative where the resident wishes, to ask whether they want to stay in their current room, return to their previous room or choose another available room now that works are complete. Access to independent advocacy is offered. PAS attended the centre on 24th September to give a talk to residents and staff. • For any future room move, for works or any other operational reason, the Resident and Family Engagement Protocol and Consent Documentation (GHI-WOC-06) applies. A move will not proceed unless the reason has been explained in a way the resident understands; the resident has been offered options; the resident's choice and any concerns are recorded; advocacy has been offered; and the move is reviewed with the resident within seven days. Where a resident does not agree, the move does not proceed without review by the Head of Operations, and any unresolved concern is managed as a complaint. <p>Consultation and participation — Regulation 9(3)(d)</p> <ul style="list-style-type: none"> • Residents' meetings are held monthly. Minutes record what residents said, the action taken and the feedback given at the next meeting. Any expression of dissatisfaction is entered on the complaints register (see Regulation 34), and this is recorded on the senior management weekly check. • Residents and their families will be consulted at the residents' meeting in the week commencing 28th September 2026, on how the refurbished communal spaces are used and arranged. Their views will be recorded and acted on. <p>Activities that reflect residents' interests</p> <ul style="list-style-type: none"> • A new Activities Co-ordinator took up post on 4 August 2026. Community outings and visiting events have increased since then. • A 'What Matters to Me' profile (GHI-WMTM suite), recording in the resident's own words what is important to them and how they prefer to spend their time, has been completed for 3 of 23 residents. Profiles will be completed for every resident by 11th December 2026, and each resident's activity plan is drawn from their profile. • Activities are provided five days a week. Participation and refusals are recorded daily. The Person in Charge reviews activity records weekly, and any resident with no recorded meaningful engagement for two consecutive days is reviewed and offered one-to-one or individually meaningful activity. A key focus for Bushfield is on individual activities owing to the dependency levels and choices of our residents. 	

Monitoring

- Activity provision, residents' meeting actions and room-move reviews are reported monthly to the Quality and Safety Committee, and residents' views are sought at each weekly senior site visit.

Responsible

Person in Charge, with the Activities Co-ordinator. Provider oversight: Head of Operations, Older Persons Services.

Compliance date

30 September 2026. What Matters to Me profiles for all residents, which sustain compliance, will be completed by 11th December 2026.

nce, will be completed by 11th December 2026..

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

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2026
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.	Not Compliant	Orange	22/09/2026
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	22/09/2026

Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	21/09/2026
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.	Substantially Compliant	Yellow	30/09/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	30/07/2026
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	Not Compliant	Red	22/07/2026

	responsibilities for all areas of care provision.			
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	Red	23/07/2026
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.	Not Compliant	Red	24/07/2026
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	22/09/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	24/07/2026
Regulation 28(2)(i)	The registered provider shall	Not Compliant	Red	22/09/2026

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Red	24/07/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	30/09/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's	Not Compliant	Orange	30/09/2026

	admission to a designated centre.			
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	30/09/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/09/2026
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.	Not Compliant	Orange	30/09/2026