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:	Lexington House
Name of provider:	GN Lexington Property Ltd
Address of centre:	Monastery Road, Clondalkin, Dublin 22
Type of inspection:	Unannounced
Date of inspection:	25 March 2026
Centre ID:	OSV-0007910
Fieldwork ID:	MON-0042226

About the designated centre

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

Lexington House is a residential care facility that will provide extended/long term care, respite and convalescence to adults over the age of 18 with varying conditions, abilities and disabilities. Lexington House can accommodate 92 residents, and is located in Clondalkin village. It is within walking distance of the main village and the amenities available. There are 82 single bedrooms and 5 double bedrooms, all of which have en suite facilities. 24-hour nursing care will be provided to all residents, which will be facilitated by a team of registered nurses with support from healthcare assistants. The overall nursing care will be monitored and supervised by the nursing management team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	87

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 25 March 2026	09:00hrs to 17:00hrs	Sinead Corbett	Lead
Wednesday 25 March 2026	09:00hrs to 17:00hrs	Mary Veale	Support

What residents told us and what inspectors observed

This inspection was a one day inspection conducted by two inspectors to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres) Regulations 2013 (as amended). The inspectors followed up on the compliance plan submitted by the provider following the inspection of the centre in May 2024, and also statutory notifications and unsolicited information submitted to the Chief Inspector of Social Services. This information was used to support the development of lines of enquiry for this inspection. Inspectors spoke to residents to gain insight into their lived experiences in the centre. Inspectors also spoke to staff and spent time observing the environment and reviewing documentation.

From what residents told the inspectors and from what inspectors observed it was clear that residents were enjoying a good quality of life. Inspectors spoke with seven residents and they were all complimentary about the staff and their experiences in the centre including the activities and food. Inspectors were told by residents that they were 'very happy' and 'have no complaints'. Some residents who could not verbally communicate their needs appeared comfortable and content. Staff were observed to interact in a kind manner with residents and were attentive to their needs. Inspectors observed that there was a relaxed atmosphere in the centre with music playing quietly in the corridors. Residents were going about their day in line with their own preferences, for example, residents chose when they wished to get up, what activities they wanted to participate in, and the food that they ate.

Lexington House is located adjacent to a residential area in Clondalkin Village. The centre consists of single bedrooms and twin bedrooms laid out over three floors, with a basement floor which accommodated the kitchen and laundry. Inspectors arrived to the centre in the morning and conducted a walk around of the premises. Inspectors observed a relaxed atmosphere in the centre and the centre was clean, warm and comfortable and laid out to meet the needs of the residents. Handrails on both sides of the corridors and in bathrooms supported residents to mobilise. Corridors and bathrooms were wheelchair accessible. A passenger lift was accessible to residents to mobilise in between the ground and upper floors. Residents were seen mobilising around the centre throughout the day.

Residents had access to a spacious garden. Trees and plants were well maintained and garden furniture provided a nice place for residents to sit. Residents could also access a terraced area on both the first and second floors. The terraces were spacious with planters and garden furniture. Access to all external areas was controlled by keypad, the code was displayed over the keypad inside the centre. Residents that required support, could access the garden with the support of staff. A call bell system was in place to allow residents to return into the centre if they did not remember the code.

Visitors were seen to come and go throughout the day of inspection. Residents could choose to meet their visitors in their bedrooms or in any of the communal spaces, for example residents had access to a day room and dining room on each floor. There was also a large activities room on the ground floor. A tea and coffee station was located in the reception area with individual tables and chairs. In addition residents had access to a day room and dining room on each floor. There was also a large activities room on the ground floor.

Residents were served their lunch in the dining rooms and in their bedrooms, according to their preferences. Tables were set with table cloths, condiments and the menu was displayed in the dining room. Meals were seen to be well presented and appeared appetising and nutritious. Residents who required assistance were attended to by staff in a relaxed and dignified manner.

The centre provided a laundry service for residents. All residents' whom the inspectors spoke with on the days of inspection were happy with the laundry service.

The day's social activities timetable was displayed in the centre and included Roman Catholic Mass on the television, an exercise group, art, Magic table and an evening movie. Inspectors also saw that activities included a weekly visit from the centre's dog, an annual barbecue, and a visit from a pet farm. Residents said they looked forward to the activities and were complimentary about the activities staff. Information on national independent advocacy services was displayed in the centre. The residents' guide was seen in residents' bedrooms. The inspectors observed residents attending Mass in the morning and an exercise session in the afternoon. Residents were seen attending the hairdresser throughout the day. Residents' views and opinions were sought through resident meetings and satisfaction surveys and they felt they could approach any member of staff if they had any issue or problem to be solved.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

Overall, the local management team provided good oversight to ensure the effective delivery of a safe, appropriate and consistent service on a day-to-day basis. There was a clearly defined management structure in place with clear lines of authority and accountability. The provider had progressed the compliance plan following the inspection in May 2024. On this inspection, the inspectors found that areas of improvement were required in relation to the premises, governance and management, and infection prevention and control.

The registered provider is GN Lexington Property Ltd. The person in charge is supported in the operational management of the centre by two company directors, a clinical compliance officer, an assistant director of nursing and a human resources manager. Changes have been made to the management structure in the centre to that outlined in the current statement of purpose, for example an assistant director of nursing and a clinical compliance officer have joined the management team. However, other supervisory and management posts are no longer in operation, this is discussed further under Regulation 23: Governance and Management.

On the day of the inspection, staffing levels were sufficient to meet the assessed needs of the residents. In addition to the person-in charge, there were five registered general nurses and sixteen health-care assistants rostered on duty. Also, there were housekeeping, activities, catering, administration and maintenance staff. Residents were seen to be supported in a timely manner by staff, for example during meal times.

There was an ongoing schedule of training in the centre. A review of records showed that no staff were overdue training in areas such as safeguarding, fire safety, manual handling, and infection control. Staff with whom the inspectors spoke with, were knowledgeable regarding infection prevention control, fire safety and safeguarding procedures.

There were good systems in place for monitoring the quality of care delivered in the centre, for example there was an ongoing audit schedule in progress. Audits identified areas for improvement and time-bound action plans were developed to address deficits and drive quality improvement. The annual review for 2025 was completed and included all regulations with an aim for each identified. The complete quality improvement plan was not available for review on the day of inspection, however it was submitted within two days of the inspection. A review of staffing identified that it did not currently align with the statement of purpose that the centre was registered against, this too is discussed under Regulation 23: Governance and management.

Clinical governance meetings were held monthly and provided oversight of incident management, such as the analysis of falls. A review of incidents that required notification to the Office of the Chief Inspector were submitted within the required time line.

There was an effective system of complaints management in the centre, residents said they could raise issues with staff. The centre had an identified complaints officer and review officer. A review of a sample of complaints showed that complaints were investigated and concluded according to the regulations.

A sample of staff files were reviewed and they all met the requirements outlined in Schedule 2 of the regulations. Digital records were maintained securely with protected access.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes. The inspectors

followed up on incidents that were notified in the previous twelve months and found these were managed in accordance with the centre's policies.

Regulation 15: Staffing

On the day of the inspection, there were sufficient staff, with an appropriate skill mix to meet the individual and collective needs of the residents in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were up to date in training on fire safety, safeguarding, managing responsive behaviours and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles.

Judgment: Compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to the inspector. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

While there were good governance and management systems in place, some gaps were identified as follows that required action:

- While acknowledging that an assistant director of nursing post and a clinical compliance officer post had been added to the management team since the previous inspection, this did not fully address the reduction in whole time equivalent posts from those outlined in the centre's statement of purpose that they are currently registered against.

1. the number of clinical nurse managers (CNM1) was reduced from four to one resulting in an overall reduction of nursing whole time equivalent posts and reducing the level of clinical management and supervision in the centre.
2. the number of healthcare assistant managers/supervisors was reduced from three to none. While this did not result in an overall reduction of the healthcare assistant staff posts and acknowledging that an internal mentorship programme had been completed by six healthcare assistants, it did not provide assurances that the same level of supervision and management systems were maintained in the centre.

- There was a lack of oversight of infection control practices did not ensure full compliance with the regulation, this is discussed further under Regulation 27: Infection control.
- There was a lack of oversight of premises that did not ensure that all requirements outlined in Schedule 6 of the regulations were fully met, this is discussed further under Regulation 17: Premises.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the office of the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had a current policy outlining the procedure for managing complaints and the person in charge had completed training on managing complaints. A review of records showed that verbal complaints were managed in a timely manner with associated actions and outcome recorded. Written complaints were recorded in greater detail, outlining the nature of the complaint, investigation, outcome and learnings.

Judgment: Compliant

Quality and safety

Overall there were good local systems in place to support the delivery of quality care to residents. Nonetheless, the registered provider was required to take action to provide additional oversight of infection control and call bell access to ensure best possible outcomes for residents. This is discussed further under the relevant regulations.

Good practice was observed in the area of care planning for residents. The inspectors viewed a sample of electronic care plans and found that care plans were developed within 48 hours of the resident's admission to the centre. Validated assessment tools were used to assess risks such as falls, pressure ulcers, and malnutrition and care plans were developed accordingly. Care plans were person-centred and were detailed to direct care to address the needs identified following assessment. Care plans were updated at a minimum of four monthly.

Records reviewed by the inspectors identified that residents have access to medical care and input from health and social care professionals, such as general practitioners, physiotherapy, speech and language therapy and tissue viability nursing. A physiotherapy programme was implemented in the centre. Care plans viewed included the recommendations of health and social care professionals. The national transfer document was utilised to communicate with hospitals in the event of hospital transfer. A system was in place to share discharge information with relevant services.

Staff had completed safeguarding training and staff that spoke with inspectors were knowledgeable of their role in protecting residents from abuse and in reporting concerns. The provider acted as a pension agent for a small number of residents and there is a robust system in place to record this and to facilitate the resident to access to their money. A review of records and discussion with the person in charge showed that safeguarding incidents and allegations had been investigated according to the provider's own policy. The local safeguarding policy references the HSE (2014) 'Safeguarding Vulnerable Persons at Risk of Abuse- National Policy and Procedures' and the safeguarding policy is available for all to read in the information area in the reception. The centre's safeguarding statement is displayed on the wall in the reception area. The provider was acting as a pension agent for four residents living in the centre. There were robust accounting arrangements in place and monthly statements were furnished. The provider held small quantities of monies in safe keeping for three residents. The provider had a transparent system in place where all lodgements and withdrawals of residents' personal monies were signed by two staff.

The inspectors reviewed residents' records and saw that where the resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Staff were employed in the centre to facilitate a programme of structured daily activities; these included yoga, art and exercise class. Residents had access to Wifi, books, television and radio. Resident meetings were held on a monthly basis. These meetings ensured the residents were kept up to date and participated in the organisation of the centre. They also offered residents an opportunity to provide feedback or suggestions and how to improve the service provided to them, for example, in areas such as activities, meals, laundry and care provision. Records showed that items raised at resident meetings were addressed by the management team.

On the day of inspection, the centre was warm and comfortable. Residents had a choice of communal spaces in the centre and there was adequate space for activities to take place. Bedrooms were clean and decorated with residents' own personal belongings and residents had adequate space for personal items and lockable storage in their bedrooms. Twin rooms were spacious and curtains afforded privacy for the residents. Call bells were missing in some bedrooms and in the first floor terrace and garden.

Inspectors identified examples of good practice in the prevention and control of infection. For example, staff were observed to apply basic infection prevention and control measures known as standard precautions to minimise risk to residents, visitors and their co-workers, such as hand hygiene, appropriate use of personal protective equipment and safe handling and disposal of laundry, sharps and waste. However, some practices can increase the risk of cross contamination and these are discussed under Regulation 21: Infection Control. Water samples taken most recently to detect Legionella bacteria were in normal range. Information on flu vaccination and norovirus was displayed in the centre.

Fire safety equipment, such as fire extinguishers, running man exit signs and smoke detection devices were located throughout the centre and fire doors were equipped with door closure devices. Fire extinguishers had been serviced in October 2025. Staff had completed training on fire safety and staff confirmed to inspectors that they had participated in simulated fire drills on a regular basis. Records of fire drills identified that where fire drills were ineffective and actions were taken to address this. Fire safety procedures and evacuation maps were displayed on the walls. The fire alarm panel was located on the ground floor and a visual check of the fire alarm panel identified that no faults were noted. Designated smoking areas in the garden and terraces were equipped with a fire extinguisher and fire blanket.

Regulation 17: Premises

Parts of the premises did not fully conform to the matters set out in schedule 6 of the regulations as evidenced by:

- Call bells were not available in all bedrooms.
- The call bell was missing on the terrace on the first floor.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

A validated assessment tool was used to screen residents regularly for risk of malnutrition and dehydration. Residents' weights were closely monitored and there was timely referral and assessment of residents' by the dietician. Meals were pleasantly presented and appropriate assistance was provided to residents during meal-times. Residents had choice for their meals and menu choices were displayed for residents.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors reviewed a sample of residents' records and saw that where a resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 27: Infection control

Practices did not fully comply with HIQA National Standards for infection prevention and control in community services (2018) and pose a risk of cross contamination, for example:

- Inspectors were told that staff decant the contents of urinals and bedpans into the toilet prior to placing them in the bedpan washers.
- Cleaning spray bottles were noted hanging from the racking in two sluice rooms.
- Glass vases were stored on a shelf under the stainless steel sink in one sluice room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Measures were in place to ensure residents' safety in the event of a fire in the centre and these measures were kept under review. Fire safety management servicing and checking procedures were in place to ensure all fire safety equipment was operational and effective at all times. Daily checks were completed to ensure fire exits were clear of any obstruction that may potentially hinder effective and safe emergency evacuation. Each resident's evacuation needs were regularly assessed and the provider assured themselves that residents' evacuation needs would be met with completion of regular effective emergency evacuation drills. All staff had completed annual fire safety training specific to Lexington Nursing home and were provided with opportunities to participate in the evacuation drills.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Based on a sample of care plans viewed, appropriate interventions were in place for residents' assessed needs. A wide range of validated assessment tools were used to assess risks such as falls, pressure ulcers, and malnutrition and care plans were developed accordingly. Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a wide range of medical and health and social care professionals, such as general practitioners (GPs), physiotherapy, dietician, speech and language therapy and mobile x-ray. Residents had access to aids and appliances to maximise their independence and reduce risks, such as pressure ulceration.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date centre specific policy was in place. Staff were aware of the signs of abuse and of the procedures for reporting concerns.
Judgment: Compliant
Regulation 9: Residents' rights
Residents' rights and choice were promoted and respected in this centre. There was a focus on social interaction led by staff and residents had daily opportunities to participate in group or individual activities. Access to daily newspapers, television and radio was available. Details of advocacy groups was on display in the centre.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lexington House OSV-0007910

Inspection ID: MON-0042226

Date of inspection: 25/03/2026

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 registered provider wishes to clarify that there has not been a reduction in the overall whole-time equivalent (WTE) staffing levels within the centre. The centres' current staffing complement is 102 WTEs, which exceeds the 98.5 WTEs outlined in the registration statement of purpose reviewed at the time of inspection. The changes implemented within the management structure were undertaken as part of a planned redistribution of roles and responsibilities to strengthen clinical oversight and increase staff support on the floor. While the number of Healthcare Assistant Manager/Supervisor posts and CNM posts were revised, the provider introduced alternative supervisory and compliance structures to ensure operational oversight was enhanced. A Clinical Compliance Officer and ADON role were introduced to strengthen regulatory compliance, governance, auditing systems and oversight of safety and quality practices within the centre. This has allowed administrative and compliance-related duties previously undertaken by Health Care Assistant Management/Supervisory Roles to be redistributed appropriately. In addition to this, the previously single Healthcare Assistant Supervisor Role has been replaced with six (6) Healthcare Assistant Mentors. These positions are support roles with strong emphasis on direct floor-based supervision, as all admin duties have been removed. This model has enhanced oversight across all three floors and provides improved accessibility to supervision for staff across a seven-day roster, compared with the previous model which was limited to one supervisory post operating over three floors, five days per week. The six Healthcare Assistant Mentors have completed an internal mentorship and supervisory development training to support them in their responsibilities, and their roles include providing direct supervision and guidance to health care team on the floor, monitoring care practices and documentation, escalating concerns appropriately to Nursing Management and promoting consistent standards of resident's care across all floors. To ensure the effectiveness of the revised management and supervision structure, the following measures are in place: 1. Monthly governance meetings are held involving the person in charge, and a representative from

all departments to review items such as staffing oversight, incidents, audits and quality improvements. 2. Floor Based Audits are being conducted on a weekly basis by the Assistant Director of Nursing to ensure the new structure has been effective in maintaining and improving staff compliance and care practices. The findings are reviewed through the clinical governance structure. 3. Residents Meetings are held on a monthly basis, and they discuss the care provided by staff to ensure the changes have a positive impact on the standard of care to the residents. All findings are discussed at the Clinical Governance Meetings. 4. Management Structure and Skill Mix will continue to be reviewed on an ongoing basis by the Registered Provider and Person in Charge to ensure the model remains effective, responsive to the residents' needs and compliant with regulatory requirements. In relation to nursing management, the provider has restructured the clinical oversight model rather than reducing it. The centre currently has two Clinical Nurse Managers in post, in addition to the Director of Nursing, Assistant Director of Nursing and Clinical Compliance Officer, all of whom provide clinical oversight and support within the centre. One additional CNM post has already been recruited since the previous inspection, and the provider is actively recruiting for a further CNM position to further strengthen the clinical governance and management structure within the centre. These measures ensure that supervision, clinical oversight and governance arrangements within the centre are maintained in a manner that is structured, measurable and focused on improving resident outcomes, staff support and regulatory compliance. The provider believes the revised structure has enhanced the quality of supervision through increased floor-based oversight across all floors and across a seven-day roster, allowing for more responsive support, monitoring and escalation processes.

In relation to the further two points, covering Premises and Infection Control please refer to the following two answers which address these concerns.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider acknowledges the findings during the inspection in relation to premises. All bedroom call bells were reviewed immediately following the inspection to ensure accessibility and functionality for residents. In addition, the call bell on the first-floor terrace was immediately replaced. The provider wishes to outline that the first floor accommodates short-term residents, and the call bell has been subject to repeated removal and damage. As such, to reduce the risk of reoccurrence and strengthen the oversight measures, an enhanced environmental safety and monitoring system is now in place. A staff member on each floor are required to complete a daily documented environmental safety round, which includes verification that all call bells are present and accessible. Any deficits identified are escalated immediately to maintenance or nursing management for prompt action. In addition, intentional rounds are completed daily by Healthcare Assistants, and checking residents call bells forms part of this process. A maintenance book is in operation within the centre and allows for staff to document

immediately when a call bell is broken, missing removed. This ensures timely escalation for repair or replacement of the equipment. Additional replacement call bells have been ordered and are kept on site to ensure back-up call bells are readily available when repairs are required. The maintenance department has incorporated a call bell inspection as part of the centres monthly Health and Safety Inspection process to provide additional oversight and assurance that all call bells throughout the centre remain available and operational. In relation to the terrace call bell, maintenance is currently assessing a more permanent fixture option to reduce the likelihood of residents being able to remove the call bell from the wall in future. The Person in Charge will monitor compliance with these measures through the monthly clinical governance meetings and environmental audits to ensure the systems implemented remain effective and sustainable.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Following the inspection, meetings were held with all staff to address the correct infection control procedures in relation to urinals and bedpans, as well as the appropriate storage of items within the sluice rooms. Staff were reminded that the contents of urinals and bedpans are not to be manually decanted into the toilets, in line with best practices. All inappropriate items identified within the sluice room were removed immediately following the inspection. We recently completed education sessions with all staff on the infection control deficits highlighted during the inspection to reinforce safe practices and staff awareness. In addition, the Person in Charge is organising an in-house practical Infection Prevention and Control training session for all staff which is scheduled to take place in June 2026. This training will include practical demonstrations and competency-based guidance relating to sluice room management, decontamination process and appropriate infection control procedures. To strengthen oversight and monitoring arrangements, the Assistant Director of Nursing is conducting weekly infection control audits and will include specifically monitoring the items highlight during the inspection. The Person in Charge will provide enhanced oversight of these audits in the interim period to ensure compliance measures are fully embedded into practice. Infection Control will remain a standing agenda item on the monthly Clinical Governance Meetings, where audit findings, learnings and any further actions will be reviewed to ensure ongoing compliance and quality improvement. These measures will ensure infection control practices within the centre are strengthened and appropriately monitored.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	26/03/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	02/04/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	25/06/2026

	consistent and effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	25/06/2026