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:	Woodlawn Manor Nursing Home
Name of provider:	WL Woodlawn Care Services Ltd
Address of centre:	St Doolaghs House, Malahide Road, Balgriffin, Dublin 17
Type of inspection:	Unannounced
Date of inspection:	13 March 2026
Centre ID:	OSV-0008662
Fieldwork ID:	MON-0049937

About the designated centre

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

Woodlawn Manor Nursing Home is a purpose built designated centre built in 2023 and is spread over three floors, including a basement level for laundry and catering services. It is located in a suburban village in North Dublin. They provide 24 hour nursing care to male and female residents over the age of 18 with low, medium, and high dependency needs. They provide both short and long term care. There are places for 97 residents, with 97 single en-suite bedrooms. The centre has a range of communal areas inside, and enclosed garden area in the centre of the building.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	83

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 13 March 2026	07:00hrs to 16:45hrs	Geraldine Flannery	Lead
Friday 13 March 2026	07:00hrs to 16:45hrs	Manuela Cristea	Support
Friday 13 March 2026	07:00hrs to 16:45hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

Inspectors arrived unannounced to the centre on the morning of the inspection and immediately undertook a walk around the centre.

The centre was calm and peaceful at 07:00 in the morning. The majority of the residents were in bed asleep; a small number of residents had already started their morning routine in the privacy of their bedrooms, while some residents on the first floor were observed walking freely and unrestricted throughout the corridors.

The inspectors met with many residents during the inspection, and spoke with 16 residents and 14 relatives in more detail, to elicit their experiences of life in Woodlawn Manor Nursing Home. Overall feedback was complimentary, and many residents spoken with were happy about the standard of care provided and how quick the staff responded to their requests for assistance.

One resident said they chose to come to the nursing home themselves, and their life had not changed that much since coming to the centre. They still continued to enjoy daily visits by friends, read books and watched programs in the same way they would have done at home.

Feedback from relatives was mostly one of satisfaction about the way their loved one was taken care of and commended the staff for their kindness and attentiveness. One visitor said ‘staff are fabulous and very quick to respond’, and another said ‘it is their attention to detail' which ensures that the residents were well attended to.

Notwithstanding the overall positive feedback, some relatives expressed dissatisfaction with the quality of social care provided in particular to residents living with dementia, with one visitor saying ‘more could be done to encourage participation in activities that were suitable for some residents' needs’.

Residents and visitors expressed uncertainty about the absence of the person in charge of the centre, which is a similar feedback to that provided during the previous inspection in February 2026. They described this as a source of frustration due to the many versions they were being told of whether they were returning or not. Some said they sought clarification from staff, but said that staff themselves were unclear about when or if the person in charge would return. Inspectors heard how this created unease for residents, visitors and staff, and they expressed dissatisfaction about management's communication and engagement about this important information.

Inspectors observed numerous staff arriving to work in their uniforms. This practice posed a cross-contamination risk and increased the risk of spreading infections in

the centre. One staff who spoke with the inspectors said that they knew this practice was not in line with the local policy.

Inspectors observed that residents had a choice of breakfast, and all residents who spoke with the inspectors confirmed that they enjoyed it. However, inspectors also observed that in the morning a resident was waiting in the dining room for their breakfast since 7.20. They were dressed and ready for the day and when inspectors asked, they said they would 'love a cup of tea', but that was only provided when breakfast started after 8 o'clock.

All food was homemade in-house, and lunch was observed to include broccoli soup, baked salmon or chicken fricassee with vegetables and mash. The chef was busy in the kitchen, and said that the new oven was being put to good use as they were preparing baked goods for the St Patrick's party which was taking place later in the afternoon.

Throughout the day of inspection, staff were observed tending to residents' needs in a quiet, caring and respectful manner. However, a number of residents informed the inspectors that the environment could be 'very loud at times', especially when some staff 'speak to each other in their own language'.

Call-bells were observed to be answered without delay. However, inspectors found that a call-bell was missing from one bedroom. Inspectors informed staff and assurances were given that this would be rectified immediately.

The inspectors heard there was poor internet in the nursing home and how this affected some residents that relied on video calls and online messaging to stay in touch with family and friends. This also was seen to affect the updating of electronic care plans, causing reduced efficiency.

The premises was well-lit, warm and comfortably furnished, creating a welcoming and homely environment for residents. Residents spoke positively about their bedroom accommodation, describing the rooms as comfortable and private.

However, inspectors found that some areas of the premises were not maintained to an appropriate standard. For example, a foul odour was present in some bedrooms and en-suites, sluices and the Café area. It was particularly pungent in one bedroom and on one corridor on the first floor, and staff informed inspectors that they were trying to mask it with deodorants and room sprays.

Inspectors observed that not all equipment for use by residents was in good working order. There were numerous electric mattresses alerting either by making a noise or flashing a red light, indicating a fault or error. Staff on the ground did not understand the meaning of the error and did not have access to a manual that provided guidance on the necessary steps to take in response. As a result, there were instances found where the electric mattresses were turned off completely to stop the sound alert, and thus posing a risk to the residents' safety.

Other mattresses observed were very hard and there was a lack of assurance that they had been set appropriately and in accordance with the weight of the individual

residents. Some residents mentioned to inspectors that the mattress was hard causing them pain and during the morning handover inspectors observed night staff communicating to day staff that some residents had complained of pain in their backs.

The windows throughout the centre, but especially on one side, were visibly unclean, and one resident said, 'the one thing that bothers me are the windows in my bedroom. Every time I look at them, I do not see the trees or the birds outside, they are so dirty'.

Inspectors observed that planned daily activities were displayed on an information board and activity staff were on-site to organize and encourage resident participation in events. In the afternoon, inspectors observed a lively party led by a singer-entertainer, where residents, visitors and staff enjoyed an afternoon of song and treats, with many dressed in 'green-day' attire for the St. Patrick Day festivities.

Residents were observed receiving visitors throughout the inspection in both their bedroom accommodation, and designated visiting areas. Visitors confirmed awareness of the complaints procedure and stated that any issues previously raised had been addressed directly with the previous person in charge. Inspectors were informed that staff in the centre now had access to the complaints system and therefore were able to manage complaints.

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

Capacity and capability

This unannounced risk 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 to 2025 (as amended).
- Follow up on the urgent compliance plan issued to the provider following the previous inspection dated 17 February 2026, to address the significant issues of non-compliance identified.
- Consider unsolicited information received by the Chief Inspector, pertaining to concerns regarding the quality of care provided to residents.

The findings of this inspection were that the registered provider had put measures in place since the last inspection to safeguard all residents, including ensuring that no person was found working on the premises without a vetting disclosure. The clinical nurse managers (CNMs) were no longer covering gaps in the rota to ensure

residents' needs were met and had time to supervise care and practices, resulting in an overall improved oversight of the service and staff supervision.

The registered provider had also provided essential equipment resources, including the installation of an oven in the kitchen and repairing the hoist with weighing capability for monitoring residents' weight.

However, on this inspection inspectors continued to find issues in relation to residents' equipment, with many of the electric mattresses in use by residents not in good working order. An immediate action was issued to the provider on the day of the inspection and the immediate assurances were accepted that prompt steps would be taken to address the issue.

Given the significant risks this may have posed to residents' welfare, an urgent compliance plan was issued to the provider to ensure that all necessary corrective actions or that effective mitigations would be put in place. The response was accepted by the Chief inspector.

In addition, this inspection found that not all actions, committed to by the registered provider in the urgent compliance plan response to the Chief inspector following the February inspection, were implemented. For example, inspectors were unable to review contracts of care for two residents and were informed that they were with the resident's families. Inspectors found evidence that not all documents as outlined in Schedule 2 and 4 held in respect for each member of staff could be validated.

The registered provider is WL Woodlawn Care Services Limited. A senior clinical nurse manager (CNM) facilitated the inspection supported by a team of nurses, healthcare assistants, activity, catering, housekeeping, administration and maintenance staff.

Inspectors found a poorly defined organisational structure, with unclear lines of authority and accountability. The person in charge had resigned and the provider had failed to inform the Chief Inspector.

Following the last inspection, the provider had agreed to voluntarily cease taking admissions to the centre. While they had abided by their commitments, the findings of this inspection were such that the Deputy Chief Inspector informed the provider on the day of the inspection of a plan to issue a notice of proposed decision to attach a restrictive condition to the registration to formally stop all admissions to the designated centre until an effective governance and management structure was in place.

While an audit schedule was in place, it was not sufficiently robust. For example, the management team had carried out an electric mattress audit on 27 February 2026 and identified more than 10 mattresses that were in need for repair or service. However, at the time of inspection there had been no meaningful action taken to reduce the significant risks this posed to the residents, some of whom were frail and with compromised skin integrity.

A sample of staff records were reviewed by the inspectors and each staff had completed An Garda Siochana vetting requests prior to commencing employment. There were no volunteers working in the centre.

Records reviewed were stored securely and made available for the inspection. However, some documents reviewed did not meet the legislative requirements including the statement of purpose, directory of residents, records and contracts of care, and will be discussed under the relevant regulations.

Regulation 14: Persons in charge

There was no person in charge in the centre; the person who was notified to the Chief Inspector as person in charge had resigned. Therefore, the deputising arrangement in place was no longer relevant given that there was no expectation that the person in charge named on the register would be returning to their post.

Judgment: Not compliant

Regulation 15: Staffing

The inspectors reviewed a sample of staff duty rotas and in conjunction with communication with residents and visitors, found that the number and skill-mix of staff was sufficient to meet the needs of the residents, having regard to the size and layout of the centre. There was at least one registered nurse on duty at all times. All nurses held a valid Nursing and Midwifery Board of Ireland (NMBI) registration.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents maintained in the designated centre did not include all the following required information under Schedule 3 of the regulations for some of the recently admitted residents:

- The name, address and telephone number of the resident's general practitioner (GP).
- The name, address and telephone number of the resident’s next of kin.
- The resident's marital status.

Judgment: Substantially compliant

Regulation 21: Records

Management of records was not in line with regulatory requirements, as follows;

- Staff files reviewed did not provide assurance that the registered provider adhered to robust human resource practices. Some files reviewed did not appear in a transparent format. For example, inspectors were not assured that all the records set out in Schedule 2 and 4 were accurate; written references for staff that had been recently employed could not be verified and records in relation to recent staff employment, including interview notes were not available.
- Staff rosters were not maintained in line with the requirements of Schedule 4. For example, all staff present on the day of inspection were not included on the roster.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose, as evidenced by;

- The registered provider did not ensure that the management structure was maintained in line with the centre's statement of purpose. There was no person in charge in the centre.
- The registered provider failed to ensure that equipment resources were adequate. For example, the electric mattresses were not in good working order posing a risk to the residents' safety.

The registered provider did not have effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example,

- Record management systems were ineffective. For example, some records in staff personnel files lacked supporting evidence and data was not verifiable. Also, staff rosters did not reflect all the staff present on the day of inspection.
- The auditing system in place to monitor the service was not effective; faulty mattresses had been identified on a recent audit carried out however, no action had been taken and no risk management or quality improvement plan had been developed.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

There was no contract of care available for review for two out of the four recently admitted residents. Therefore, as required by the regulation, there was no evidence that the registered provider had agreed in writing with each resident, on admission the terms of admission to the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not accurately reflect the organisational structure in the designated centre as outlined under Regulation 14: Person in charge.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints procedure in place did not fully meet the requirements of Regulation 34 as outlined in S.I No. 628 of 2022. For example:

- The complaints procedure on display in the centre did not include information on advocacy services.
- The nominated complaint officer had not received suitable training to deal with complaints.

Judgment: Substantially compliant

Quality and safety

The overall quality and safety of care was significantly compromised by the ineffective governance and management, as detailed in the Capacity and Capability section of this report.

Care planning documentation was available for each resident in the centre. A sample of 10 residents were chosen for an in-depth review of their care records, which were held electronically across two systems, making navigation difficult. While it was evident that staff were making efforts to ensure all care plans were updated at regular intervals and assessments were carried out every four months or more frequent if required, not all care plans were sufficiently person-centred and comprehensive to inform care, and records did not always document the practices at the centre.

There were arrangements in place to safeguard residents from abuse. A safeguarding policy detailed the roles and responsibilities and appropriate steps for staff to take should a concern arise. Inspectors did not observe any safeguarding incidents of concern on the day of inspection.

Residents' choices were respected, including their right to decline. Feedback from residents was positive in respect of activities which were available seven days a week. Effective arrangements were in place to ensure that feedback from residents was considered and appeared to be informing the activities planned and provided. All interactions observed during the day were positive and residents' privacy and dignity was respected at all times. However, improvement was required to ensure that residents' rights were upheld within the centre.

The premises was of suitable size to support the numbers and needs of residents living in the designated centre. However, the registered provider was required to action works with regard to the premises, in order to provide a safe and comfortable living environment for all residents and will be discussed further under Regulation 17: Premises.

Residents' nutritional and hydration needs were met. Inspectors observed that residents' dietary needs and preferences were respected and there were appropriate systems to communicate specific dietary needs to all staff, both at unit and kitchen level.

Inspectors observed many instances of good practices in respect of infection prevention and control, however some procedures were not consistent with the *National Standards for Infection Prevention and Control in Community Services (2018)* and will be discussed further under the regulation.

Regulation 17: Premises

Premises were not in compliance with Schedule 6 of the regulations, for example;

- Ventilation was not suitable in all areas as several rooms throughout the centre, including corridors, bedrooms and en-suites, sluices and the Cafe had a strong malodour. In addition the smoking room was found to be very stuffy and the ventilation was ineffective to control the strong smell of smoke.

- Equipment to be used by residents was not all in working order and an urgent action was issued on the day of inspection to ensure that electric mattresses used by residents were repaired or appropriately calibrated. Inspectors found 10 mattresses that were not working, either turned off by staff or with red flashing alerts which posed a significant needs to the skin integrity of the residents. Some mattresses were found to be over inflated and really hard and some residents complained that they had sore backs. The provider's response to the urgent action provided the required assurance that appropriate steps had been taken. In addition, one of the bed pan washers continued to be out of order and inspectors were informed that the required parts to fix it had been ordered.
- While the centre was tidy, not all areas were clean to an appropriate standard. For example windows were visibly dirty and areas of the floors in the corridors or dining room were sticky.
- Inappropriate storage of residents' equipment such as hoists was seen in communal bathrooms, which posed a cross-infection risk. Furthermore, access to the communal bathroom facilities was locked with a keypad, preventing residents from independently using such facilities.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were offered choice at mealtimes and were provided with adequate quantities of wholesome and nutritious food. There were adequate numbers of staff to meet the needs of residents at meal times.

Judgment: Compliant

Regulation 27: Infection control

The inspectors found that the registered provider had not ensured that some procedures were consistent with the *National Standards for infection prevention and control in community services (2018).* The following findings required action:

- There was no person nominated as the infection prevention and control (IPC) lead at the centre, as required by national standards.
- Not all areas of the centre were appropriately clean; inconsistencies were noted between products used and appropriate process of chemical dilution. As a result, some floors were sticky even after being cleaned. Inspectors spoke with a number of housekeeping staff who gave different accounts in respect of the product to be used for various surfaces and the process.

- Staff practices observed were not in line with infection control procedures and guidelines. For example staff in all roles including kitchen, cleaning, nursing and healthcare roles were seen coming to and leaving work wearing their uniforms. This posed a significant cross-contamination risk and was not in line with local or national policies.
- While clinical waste and sharps was appropriately segregated at the point of use, there were excessive amounts of full sharps boxes which had not been collected since November 2025.

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;

- Many care plans were generic and repeated for all residents, and not always informed by an assessment of need. For example all residents had an identical safeguarding care plan in place, which meant that it would be difficult to establish which resident had a safeguarding need that required more focused interventions. Where additional interventions were required for residents assessed as being at risk, staff knew what measures to take to ensure residents were safe, but the practices and required interventions were not detailed in residents' care plan.
- Some end-of-life care plans were generic and did not reflect individual preferences and choices to ensure residents' wishes were identified.
- Residents at risk of developing pressure sores had the same repositioning arrangements as residents who had developed a pressure sore. While it was clear that wounds were well followed up with input from tissue viability nurse specialists, the pressure relieving equipment was not supportive of residents' needs.
- Care plans clearly outlined the likes and dislikes of residents and the activities they enjoyed, however there were numerous gaps in the records of participation in activities and as a result it was difficult to ascertain how the residents had spent their day, especially for those residents who did not participate in group activities.
- Continence assessments were completed but required to be more specific. For example, the size and required absorbency of continence wear was not indicated, which posed a risk that the resident could be provided with the wrong product.
- Not all care plans interventions were implemented in practice and there were some discrepancies between the information available on staff handover sheets and the guidance outlined in care plans. For example, in respect of intervals for safety checks to be completed, it was not specified whether hourly or half hourly.

Judgment: Not compliant

Regulation 8: Protection

Staff were trained and understood the principles of safeguarding residents and their responsibility to report any incident of suspected or observed abuse. Residents reported that they felt safe at all times. All staff working in the centre had a valid Garda vetting in place. The provider was not a pension-agent for any resident.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors were not assured that residents rights were being maximised and fully supported, as evidenced by:

- Residents reported that some staff spoke to each other in their native language while in their presence. This was not appropriate and may compromise the residents' care, dignity and understanding while also making them feel excluded, disrespected or uncomfortable.
- Based on feedback from visitors, action was required in relation to supporting residents' rights to meaningful occupation and social engagement, in particular those living with dementia.
- Unreliable broadband meant that the residents could not use the Internet meaningfully, which was essential for emotional health and life satisfaction.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Woodlawn Manor Nursing Home OSV-0008662

Inspection ID: MON-0049937

Date of inspection: 13/03/2026

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • A suitably qualified and experienced Person in Charge (PIC), who meets the requirements of Regulation 14, commenced in full-time post on 05/05/2026. The PIC is supernumerary and has full responsibility and accountability for the clinical, operational and governance oversight of the designated centre. • Notification regarding the change of Person in Charge was submitted to the Chief Inspector on 05/05/2026 in line with regulatory requirements. Supporting documentation has been maintained within the centre's governance records. • The governance and management structure within the designated centre has been formally reviewed by the Registered Provider on 05/05/2026 to ensure clear lines of authority, accountability, escalation and operational oversight are in place. The updated organisational structure has been communicated to staff, residents and relatives and displayed in the centre. • The Statement of Purpose, organisational chart and management responsibilities have been updated on 06/05/2026 to accurately reflect the current management arrangements within the designated centre. • Formal deputising arrangements have been implemented to ensure management cover is maintained at all times during planned or unplanned absences of the PIC. The designated deputy responsible during periods of leave is the ADON with clearly defined responsibilities, reporting arrangements and escalation pathways. • Weekly governance and management meetings involving the Registered Provider Representative, PIC and senior management team have been implemented from 11/05/2026. These meetings include review of regulatory compliance, incidents and safeguarding, staffing and roster oversight, complaints, infection prevention and control, audits and quality improvement actions, risks and escalation concerns. • A governance oversight schedule has been introduced to monitor the effectiveness of management systems within the centre. This includes regular provider oversight, review of action plans, compliance monitoring and escalation tracking to ensure sustained compliance with Regulation 14.	

• The effectiveness of the revised governance and management arrangements will be reviewed monthly by the Registered Provider and Person in Charge to ensure ongoing compliance, effective leadership, continuity of care and resident safety.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:

• A full review of the Directory of Residents was completed on 14/05/2026 to ensure all information required under Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 is accurately recorded and maintained.
• The missing information identified during inspection, including residents' general practitioner details, next of kin contact information and marital status, has now been updated and verified within the Directory of Residents.
• A standardised admission and documentation checklist has been implemented from 18/05/2026 to ensure all required resident information is obtained, reviewed and recorded at the time of admission.
• The Person in Charge (PIC) and/or ADON will complete a monthly audit of the Directory of Residents to ensure all required information remains complete, accurate and up to date in line with Schedule 3 requirements.
• Any omissions or discrepancies identified through audit or daily oversight processes will be addressed immediately with corrective actions recorded and monitored through the centre's governance and quality improvement systems.
• Ongoing oversight of resident records will form part of the centre's governance and compliance monitoring arrangements to ensure sustained compliance with Regulation 19.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• A full review of staff personnel files has been completed to ensure that all records required under Schedules 2 and 4 of the regulations are available, accurate and maintained in a clear and transparent format.
• Missing documentation, including employment references and records relating to recruitment processes, has been sought and updated where required.
• Recruitment and file management practices have been reviewed with the management

team to ensure robust human resource procedures are consistently implemented.
• A standardized checklist has been introduced for all staff files and checked monthly or as required by Admin and PIC to ensure all required documentation is obtained, verified and retained prior to commencement of employment.
• PIC has reviewed roster management processes to ensure rosters accurately reflect all staff working in the designated centre on each shift, in line with Schedule 4 requirements.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A qualified and experienced Person in Charge (PIC), who meets the requirements of Regulation 14, commenced in full-time post on 05/05/2026, ensuring that the management structure within the designated centre is maintained in line with the Statement of Purpose and regulatory requirements.
• The Registered Provider has completed a review of the governance and management arrangements within the designated centre on 05/05/2026 to ensure clear lines of authority, accountability, escalation and operational oversight are in place across all areas of service delivery.
• Faulty electric mattresses identified during inspection and through internal audits were immediately removed from use. All affected mattresses have now been repaired, serviced, recalibrated or replaced as appropriate to ensure resident safety, comfort and effective pressure area care.
• A full equipment audit has been implemented from 25/05/2026 to ensure all clinical and non-clinical equipment is safe, functional, appropriately maintained and serviced in accordance with manufacturer guidance. Any issues identified through audit are recorded on the centre's maintenance log and risk register, with corrective actions assigned to a responsible person and monitored to completion.
• Governance and oversight systems within the centre have been strengthened to improve the monitoring of the quality and safety of care provided to residents. Weekly and monthly governance meetings involving the Registered Provider Representative, PIC and senior management team have been implemented from 11/05/2026.
• The governance meetings include review and oversight of incidents and accidents, safeguarding, staffing and dependency levels, infection prevention and control, complaints and residents' feedback, care plan audits, medication management, restrictive practices, risk management, maintenance and environmental issues, quality improvement plans and regulatory compliance.
• Record management systems, including staff personnel files, resident records and staff rosters, have been fully reviewed to ensure records are complete, accurate, secure and verifiable in line with Schedules 2, 3 and 4 of the regulations.
• A standardised audit schedule has been introduced to ensure all clinical and non-clinical

audits are completed within defined timeframes. Each audit now includes identified findings, action plans, named responsible persons and completion dates.
• The centre's Quality Improvement Plan (QIP) and Risk Register have been reviewed and updated by PIC to ensure all identified risks, non-compliances and service improvement actions are monitored, escalated and reviewed through the governance structure until completed.
• The Registered Provider Representative will complete regular provider oversight visits and compliance reviews to monitor the effectiveness of governance arrangements and ensure sustained compliance with Regulation 23.
• The effectiveness of governance and management systems will be reviewed monthly through audit analysis, governance meetings and provider oversight to ensure continuous quality improvement, resident safety and sustained regulatory compliance.

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
• A full review of all admission documentation and Contracts of Care was completed on 15/05/2026 to ensure compliance with Regulation 24 and Schedule 1 requirements.
• Contracts of Care have now been completed, signed and made available within the residents' records for all residents residing in the designated centre, including those identified during inspection.
• Each Contract of Care clearly outlines the terms and conditions of residency, including the services to be provided, bedroom occupancy arrangements, applicable fees and charges, additional services where relevant and residents' rights and responsibilities in accordance with regulatory requirements.
• A standardised admission checklist has been introduced from 18/05/2026 to ensure all required admission documentation, including the Contract of Care, is completed, signed and reviewed at the time of admission.
• The Person in Charge (PIC) or delegated senior manager ADON/CNM will review all new admissions within 48 hours to ensure Contracts of Care and associated admission documentation are fully completed and securely maintained within the resident's records.
• Monthly audits of admission documentation and Contracts of Care have been implemented from 18/05/2026 to monitor ongoing compliance with Regulation 24 and identify any omissions or discrepancies promptly.
• Any issues identified through audit or governance review processes will be addressed immediately, with corrective actions recorded, monitored and escalated through the centre's governance and quality improvement systems.
• Ongoing oversight of admission documentation compliance will form part of the centre's governance and management monitoring arrangements to ensure sustained compliance with Regulation 24.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been fully reviewed and updated on 06/05/2026 to ensure it accurately reflects the current service provided within the designated centre and complies with the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.
• The updated Statement of Purpose now accurately reflects the current organisational and management structure within the designated centre, including the appointment and reporting arrangements of the current Person in Charge, in line with Regulation 14 requirements.
• The revised Statement of Purpose also includes updated details regarding staffing arrangements, governance structure, services and facilities provided, admission criteria, dependency levels supported, complaints procedure and arrangements for safeguarding and residents' rights.
• The updated Statement of Purpose has been communicated to residents, relatives and staff and is available within the designated centre in accordance with regulatory requirements.
• A formal review process has been implemented to ensure the Statement of Purpose is reviewed at least annually, and sooner where there are significant changes to the service, management structure or operational arrangements within the designated centre.
• The Person in Charge and Registered Provider Representative are responsible for ongoing review and monitoring of the Statement of Purpose to ensure the document remains accurate, up to date and reflective of the service delivered.
• Ongoing oversight and review of the Statement of Purpose will form part of the centre's governance and compliance monitoring systems to ensure sustained compliance with Regulation 3.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The complaints procedure within the designated centre was reviewed and updated on 12/05/2026 to ensure full compliance with Regulation 34 and S.I. No. 628 of 2022.
• The updated complaints procedure now includes clear information regarding

independent advocacy services available to residents and their representatives, ensuring residents are supported and informed when making or pursuing a complaint.
• The revised complaints procedure has been displayed prominently throughout the designated centre and made available in accessible formats appropriate to residents' needs, including large print and support from staff where required.
• The nominated Complaints Officer completed formal complaints management training on 04/12/2025 to ensure complaints are managed promptly, fairly, consistently and in accordance with the centre's complaints policy and regulatory requirements.
• The Review Officer and relevant staff members will complete complaints management training by 24/06/2026 to strengthen oversight, review processes and staff knowledge regarding complaint handling and escalation procedures.
• All staff have received refresher guidance regarding the complaints policy, residents' rights and their responsibility to support residents to raise concerns or complaints without fear of negative consequences.
• A system has been implemented to ensure all complaints, concerns and feedback are recorded, reviewed, responded to and monitored appropriately, including acknowledgement of complaints, investigation outcomes, actions taken, satisfaction with outcome and escalation where required.
• The Person in Charge (PIC) will complete monthly reviews and quarterly audits of the complaints log to ensure complaints are managed in line with policy, response timeframes are met, learning outcomes are identified and quality improvement actions are implemented.
• Complaints trends, learning outcomes and actions taken will be discussed at governance and management meetings to support continuous quality improvement and improved resident experience within the designated centre.
• Ongoing monitoring and oversight of complaints management arrangements will form part of the centre's governance systems to ensure sustained compliance with Regulation 34.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• A comprehensive environmental and premises review was completed on 22/05/2026 to assess compliance with Schedule 6 requirements and identify areas requiring corrective action within the designated centre.
• A full review and servicing of ventilation systems has been completed throughout the centre, including bedrooms, corridors, en-suites, sluice rooms, communal areas, café area and smoking room.
• Measures have been implemented to improve air circulation and reduce malodours, including enhanced cleaning schedules, servicing of ventilation systems, and the introduction of monthly environmental checks to ensure adequate air quality is maintained.

• All electric mattresses identified as faulty or incorrectly functioning have been removed from use, repaired, replaced, or recalibrated in accordance with manufacturer guidance and residents' assessed needs.
• A daily equipment safety checking system and a monthly equipment audit have been implemented to ensure all resident equipment remains safe, functional and suitable for use. Any faults identified are immediately escalated to maintenance and recorded on the maintenance log and risk register until resolved.
• The bed pan washer identified during inspection has been repaired and is now fully operational. Preventative maintenance arrangements and servicing schedules have also been reviewed to reduce the risk of future equipment failures.
• Cleaning systems within the centre have been reviewed and strengthened. Cleaning schedules have been updated, with increased monitoring of high-traffic and high-touch areas, including windows, floors, communal dining areas, and bathrooms.
• An environmental audit and a weekly walkaround inspections will be completed by management and housekeeping supervisors, with findings discussed at governance meetings and actions monitored to completion.
• Storage arrangements for resident equipment, including hoists and mobility equipment, have been reviewed and reorganised to ensure safe and appropriate storage practices that minimise cross-infection risks and maintain safe access to communal areas.
• Staff have received instruction regarding appropriate storage procedures, environmental safety responsibilities and escalation processes for maintenance or environmental concerns.
• Access arrangements to communal bathroom facilities were reviewed on 22/05/2026. Residents now have unrestricted and appropriate access to communal bathroom facilities in line with their assessed needs, independence and residents' rights.
• Ongoing premises oversight will form part of the centre's governance and quality improvement programme, including environmental audits, maintenance reviews, health and safety inspections and provider oversight visits to ensure sustained compliance with Regulation 17 and Schedule 6 requirements.

Regulation 27: Infection control	Not Compliant

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

• A designated Infection Prevention and Control (IPC) Lead has now been identified within the centre, in line with national standards. The IPC Lead is responsible for overseeing infection prevention and control practices, ensuring adherence to policies, providing guidance to staff, and monitoring compliance through audits and supervision.
• All cleaning procedures and environmental hygiene practices within the designated centre were reviewed and standardised to ensure consistency in cleaning methods, product usage, dilution procedures and infection prevention practices across all departments.

• Refresher IPC training was provided to housekeeping staff on 27/03/2026 with particular focus on correct cleaning techniques, colour coding systems, safe preparation and dilution of cleaning chemicals, management of contaminated equipment and environmental hygiene standards.
• All staff across nursing, healthcare, catering, housekeeping and maintenance departments have received refresher education regarding standard precautions, hand hygiene, PPE use, uniform management and infection prevention and control responsibilities.
• A specific directive has been issued to all staff on 15/05/2026 that uniforms must not be worn to and from work in line with national IPC guidance and centre policy.
• Compliance with uniform management, hand hygiene and infection prevention procedures will be monitored through daily supervision, spot checks, environmental walkarounds and monthly IPC audits.
• A strengthened IPC audit programme has been implemented to ensure ongoing monitoring of cleanliness standards and adherence to procedures.
• Findings from IPC audits are reviewed monthly through governance meetings, with action plans developed, responsibilities assigned and completion dates monitored through the centre's quality improvement systems.
• Clinical waste management arrangements have been reviewed with the approved waste contractor on 30/03/2026 to ensure timely collection of sharps containers and clinical waste.
• Accumulated sharps bins identified during inspection were immediately removed from the centre and an updated waste collection schedule has now been implemented to ensure ongoing compliance and prevent recurrence.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• A comprehensive review of all residents' assessments and care plans has been completed to ensure that each care plan is based on a current, comprehensive assessment of need and reflects the individual preferences, clinical requirements, and personal choices of each resident. Generic and duplicated care plans, including safeguarding, end-of-life, pressure care, and continence care plans, have been discontinued and replaced with individualised care plans specific to each resident.
• End-of-life care plans have been reviewed and updated to clearly reflect residents' wishes, choices, advanced care decisions, spiritual preferences and family involvement where appropriate, ensuring dignity, autonomy and person-centred end-of-life care planning.
• Pressure ulcer prevention and management care plans have been revised to ensure care interventions reflect individual risk assessments, repositioning requirements, skin integrity monitoring, nutritional support needs and appropriate pressure-relieving

equipment.
• Continence assessments and care plans have been updated to clearly specify continence products required, including product type, size, absorbency level and frequency of monitoring, to ensure residents receive appropriate and dignified continence care.
• Activity participation records have been strengthened to ensure daily records accurately reflect residents' engagement, preferences, and meaningful activities, including for residents who do not participate in group activities.
• All care plans have been reviewed to ensure that interventions are clearly defined, measurable, and consistently implemented in practice. Discrepancies between care plans, staff handover information, and daily practice have been addressed through updated documentation, staff training, and improved communication systems.
• All nursing staff will receive refresher guidance and support on person-centred care planning, documentation standards and accurate recording practices by 31/07/2026.
• A monthly auditing of care plans and assessments has been introduced to ensure ongoing compliance, accuracy, and consistency between documented care plans and care delivered in practice.
• Audit findings, identified deficits and required actions are discussed at clinical governance meetings, with corrective actions assigned to responsible staff and monitored to completion through the centre's quality improvement systems.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• All staff have been reminded of their responsibility to ensure that residents are always treated with dignity and respect. A specific directive has been issued on 15/05/2026 that staff must communicate in English in the presence of residents at all times. This requirement has been reinforced through staff meetings, supervision, and ongoing monitoring by the Person in Charge and management team.
• Weekly activity calendar is under review and will be updated by 15/06/2026 to ensure a wider range of individual and group activities are available, including meaningful activities, particularly for residents living with dementia and cognitive impairment.
• Residents who choose not to participate in group activities are now offered one-to-one engagement and alternative meaningful activities in line with their assessed preferences and wishes.
• Activity participation, resident feedback and social engagement outcomes will be monitored through daily documentation, residents' meetings, and care plan reviews
• The Registered Provider has reviewed internet and broadband services within the designated centre following concerns identified during inspection. Arrangements have been implemented with the service provider to improve broadband reliability and internet access throughout the centre.
• The Person in Charge and management team will continue to monitor residents' rights, communication practices, meaningful occupation and access to services through

governance meetings, resident feedback, audits and quality improvement reviews to ensure sustained compliance with Regulation 9.

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 14(1)(a)	The registered provider shall ensure that the designated centre has a person in charge.	Not Compliant	Orange	08/05/2026
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	Red	31/07/2026
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	31/05/2026
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	Not Compliant	Orange	31/05/2026

	the Chief Inspector.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/05/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/05/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2026
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms,	Not Compliant	Orange	31/07/2026

	including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
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	Orange	31/07/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Not Compliant	Orange	31/05/2026
Regulation 34(5)(b)	The registered provider may, where appropriate assist a person making or seeking to make a complaint, subject to his or her agreement, to identify another person or independent advocacy service who could assist	Substantially Compliant	Yellow	31/05/2026

	with the making of the complaint.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	30/06/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/07/2026
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident is facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media.	Substantially Compliant	Yellow	31/07/2026
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious	Substantially Compliant	Yellow	31/07/2026

	persuasion, racial origin, cultural and linguistic background and ability of each resident.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/07/2026
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.	Substantially Compliant	Yellow	31/07/2026