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:	17 February 2026
Centre ID:	OSV-0008662
Fieldwork ID:	MON-0049651

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/maximum dependency needs. They provide both short and long term care. There are places for 96 residents, with 96 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
Tuesday 17 February 2026	07:00hrs to 19:10hrs	Geraldine Flannery	Lead
Monday 23 February 2026	07:00hrs to 15:15hrs	Geraldine Flannery	Lead
Tuesday 17 February 2026	07:00hrs to 19:10hrs	Aislinn Kenny	Support
Monday 23 February 2026	07:00hrs to 15:15hrs	Aislinn Kenny	Support

What residents told us and what inspectors observed

This unannounced inspection was conducted by two inspectors of social services over two days.

Overall, residents spoke positively about their experience of living in Woodlawn Manor Nursing Home. Residents told the inspectors that 'staff were amazing' and appreciated the care they received from staff who were helpful, caring and dedicated.

Notwithstanding the positive feedback, some residents spoke about a recent deterioration in food choice, especially during the tea-time service. Some residents spoke about eggs being available most days either as an omelette, boiled, fried or scrambled. Another resident said they particularly missed their favourite potato option from the menu saying 'I would love a roast potato'.

Some residents spoken with expressed dissatisfaction about not being kept informed about 'goings-on' in the centre. For example, residents had not being informed about works that commenced in an internal courtyard. Some residents described a negative experience as a result of workmen just 'appearing outside their window', and preceded to close the curtain to maintain their privacy.

A few residents said they 'would like more to do during the day' and wished there were more activities tailored to their preferences. Residents reported that they would provide this feedback at the next resident meeting saying that 'there should be one due soon'.

Residents and visitors who spoke with inspectors expressed their 'unease' about the uncertainty regarding who was in charge of the centre. One resident spoke about the lack of leadership in the centre and told inspectors 'it's chaos here at times, no one knows who is in charge'. Another resident said that they had not seen the person in charge recently which was 'unusual', while another resident said that 'the place is not as lively' without the person in charge.

Some visitors spoken with described the situation as 'frustrating', and stated that any issues previously raised had been addressed directly with the person in charge but that they 'hadn't seen them around lately, which was strange'. One visitor explained that when they sought clarification from staff, about who held responsibility and to whom their concerns should be directed, staff did not know or were unclear. One visitor asked the inspectors 'who is in charge here'.

Inspectors found that although the residents were well cared for by staff, there were significant concerns in respect of the governance and systems of management

oversight and their capability to ensure a safe and high-quality service was consistently provided to the residents living in the designated centre.

There were 83 residents residing in Woodlawn Manor Nursing Home on the first day of inspection. The centre was set out over three floors, with resident accommodation located on the ground and first floors which was accessed by a passenger lift and stairwell.

Inspectors arrived unannounced to the centre early on the first morning and immediately undertook a walk around the centre. Inspectors met with staff working on the night shift and observed the early morning routine and the morning handover. The atmosphere on day one was calm and inspectors observed that most residents were sleeping in their bedrooms, while others had already started their morning routine in the privacy of their bedroom.

On the ground floor there were three healthcare assistants and one staff nurse allocated to provide care for 46 residents. The inspectors were told that there should be two nurses on duty, however due to short notice leave there was one nurse. This posed concerns in respect of the ability of one nurse to safely administer medication in a timely manner and effectively oversee the care for so many residents at night.

On the first floor, a clinical nurse manager (CNM) was covering a vacancy and working as a staff nurse with direct responsibilities for residents' care. Staff spoken with referred to the absence of the person in charge and told inspectors they were unaware who was in charge at the time of the inspection.

A brief introductory meeting was held on the morning of inspection with the CNM, who was the most senior staff member working in the centre. The person in charge was absent on statutory leave since the end of December 2025 and no one had been appointed to deputise in their absence. Staff in the centre did their utmost to facilitate the inspection, however the registered provider did not attend the centre on the day and inspectors experienced delays in obtaining some of the requested documents.

There was sufficient private and communal space for residents to relax in. The reception area was spacious with comfortable seating areas for residents and their visitors to enjoy. Inspectors observed there was a malodour in some areas of the centre such as bedroom corridors and sluice rooms. In addition, a number of areas of the centre were visibly unclean during the inspection and this and other findings will be discussed later in the report.

Maintenance staff were on site on day one of inspection and were observed working in an internal courtyard. The ground had been dug away from a section of the courtyard exposing the external wall below ground level and personnel on site were seen applying a sealant to the external walls of some bedrooms. Inspectors were informed that this was to stop moisture getting in through the wall. Inspectors observed that some rooms were not in use due to them requiring refurbishment to address dampness and malodours.

Inspectors observed some inappropriate storage in the centre. Five bottle of oxygen were observed stored in the pharmacy store. Four hoists and a weighing chair were observed in a communal bathroom. Inspectors observed that a hoist used to weigh residents was out-of-order and the bedpan washer on the first floor was not working. During the first day of the inspection the lift stopped working, and staff working in the centre addressed this on the day.

Inspectors observed the residents' dining experience and saw that staff were attentive to residents' needs throughout. Staff nurses were actively supervising the dining rooms at mealtime. Meals were attractively presented, and residents who remained in their bedrooms were freshly served their meals from the bain marie, which was transported along the corridor from room to room.

The menu of the day was displayed in the dining room and inspectors observed that roast beef was on the menu however, they were told by kitchen staff that the oven had not been working since just after Christmas. Inspectors spoke with the chef who confirmed that the oven was not in use and that the beef was not cooked in the manner described on the menu. Staff said that they were trying to be innovative and come up with a variety of menu options in the absence of the oven. For example, the previous day's menu was due to be a chicken, tomato and basil baked dish, however was substituted to sweet and sour chicken due to the absence of a working oven; on the day of inspection the beef was boiled instead of roasted.

A second inspection day was scheduled to review commitments given by the registered provider in the urgent warning meeting with the Chief Inspector following the first day of inspection, including the stopping of admissions to the centre and ensuring only vetted staff could work in the centre. Inspectors acknowledged some positive improvements including the appointment of a deputy person in charge and the installation of a new oven in the kitchen.

On the morning of the second day of inspection, two staff nurses were allocated to the ground floor and one allocated to the first floor. There were 35 residents present on the second floor and unlike on the first inspection day, inspectors observed that the atmosphere on the first floor was more hectic with some residents walking up and down the corridors, some displaying verbal outbursts. The nurse described the environment as ‘unpredictable’ with some residents having potential to display responsive behaviour (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Inspectors observed staff nurses and CNMs being interrupted from doing the medication by answering call-bells and answer other staff queries, despite wearing an apron that stated they were not to be disturbed. This meant they were required to stop the medication round to tend to other duties which posed a safety risk.

Staff on duty overnight informed inspectors that all residents that required assistance were supported, however they said that some residents had received continence wear that were not the correct size as per their individualised assessments. Inspectors reviewed the supplies and stocks of continence wear

available in the centre and observed that although there was some reserve stock available, staff were not aware of this. In addition, inspectors also became aware of institutionalised practices in respect of some residents that were given incontinence wear but in fact were continent, and that decision was not informed by a clinical assessment.

Planned daily activities were displayed on an information board. The inspectors observed some group activities and one-to-one activities such as nail care and hand massage, which the residents appeared to enjoy. On the second day of the inspection, inspectors observed residents enjoying a coffee morning. Residents informed inspectors that the chef had baked lots of home-baked cakes and treats to celebrate the installation of the new oven.

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 provided.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services over two days to;

- Monitor the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended).
- To review unsolicited information received by the Chief inspector, detailing concerns regarding the care and welfare of residents. The information was substantiated on this inspection.

The findings from this inspection were that the the registered provider had failed to ensure that there was a clearly defined management structure in place, with clear lines of accountability and responsibility, in line with the centre's statement of purpose. The provider had failed to ensure that staffing resources were available and appropriately managed in response to planned and unplanned staff leave. Within the centre, it was unclear who held responsibility for key aspects of the service such as the oversight and management of quality care, management of risks, safeguarding, admissions and the management of complaints. Furthermore, there was a concerted effort to ramp up the number of admissions at the designated centre, despite the absence of key governance and management personnel and adequate staffing resources.

The person in charge was on statutory leave and the registered provider had no deputising arrangements in place. The inspectors were informed that a company

director who was delegated by the provider for senior management oversight of the service had resigned.

The provider had a checkered history of regulatory compliance. The appointment of the person in charge in March 2025 had strengthened the governance arrangements in the centre. The most recent inspection carried out in December 2025 found that improved levels of regulatory compliance had been achieved in the centre. Care and welfare regulations achieved full compliance with significant premises issues outstanding. However, the findings of the inspection were that in the absence of a senior management structure, there was ineffective oversight of the service with inspectors finding significant failures in ensuring safe, consistent and effective care to residents. In the absence of senior management, responsibilities were delegated to more junior staff without appropriate levels of authority, support and supervision.

The systems in place to communicate key information about residents between staff were not effective. While staff attended structured handovers, information essential to the delivery of person-centred, safe and quality care was not consistently communicated. This posed a risk that compromised the overall quality and safety of care delivered to residents.

WL Woodlawn Care Services Ltd is the registered provider of Woodlawn Manor Nursing Home. The house manager, four clinical nurse managers and a team of nursing staff, care staff, housekeeping, catering, administrative and maintenance staff were present on the days of the inspection.

On day one of the inspection, no representative from WL Woodlawn Care Services Ltd made themselves available to support staff during the inspection or to engage with the inspectors. The issues of concern found on this inspection pertained to the actions of WL Woodlawn care Services Ltd and not to the staff who were working in the centre, doing their best in very difficult circumstances.

Two immediate actions and an urgent compliance plan were issued to the provider during this inspection in respect of:

- Significant safeguarding concerns: no person should be allowed working in the centre in the absence of vetting disclosures and appropriate documentation.

Immediate fire safety risks were identified on day two: an immediate action plan was issued to the provider in respect of a serious safety risk pertaining to fire precautions. The registered provider did not provide an adequate means of escape to all residents and did not take adequate precautions against the risk of fire. Satisfactory assurances were received the following day following day that mitigating measures were put in place.

The registered provider had made a decision to admit four new residents into the designated centre. Staff on duty, including those responsible for the day to day operation of the nursing home, confirmed that they were not involved in the admission process. In the absence of the person in charge or appointed deputy, inspectors were not assured that these admissions were managed in a way that was

planned, safe and in line with the registered provider's admission policy. For example, there was no evidence that residents were appropriately assessed, there were no contracts of care in place and staff in the centre were not consulted with regard to their ability to meet the care needs of the new residents.

Significant safeguarding concerns were observed on the first day of inspection including persons working in the centre undertaking relevant duties in the absence of valid Garda Vetting Disclosures. These persons, who identified themselves as 'staff', were reported as working in the centre on at least three separate dates with one present on the day of inspection. There were no Schedule 2 records on file for these persons including evidence of identity, details and documentary evidence of professional qualifications, contracts of employment or vetting disclosures. While they were not involved in the provision of personal care, they were in effect working in a direct manner with current and prospective residents and had access to their records, which posed a risk in respect of the safety of residents. An immediate action plan was issued to the provider that evening and satisfactory assurances were received that corrective action was promptly taken.

Inspectors acknowledge that immediate measures had been put in place following day one of the inspection to ensure that the identified persons were not permitted in the centre without appropriate documentation. However on day two, inspectors became aware of other persons, not on duty but present on the roster who also did not have a valid Garda vetting in place and also became aware that historically there was a practice of staff commencing work when the provider had not ensured that they had obtained a valid garda vetting disclosure.

The serious nature of the findings were such that the Chief Inspector was concerned about the registered provider's ability to sustain a safe quality service given the lack of governance structure and requested the registered provider to stop admissions into the centre until appropriate resources were put in place. The provider voluntarily agreed to do so.

The significant risk and decline in the level of compliance with the regulations, resulted in escalatory action including an urgent warning provider meeting on the day following the inspection. An urgent compliance plan was also requested, to mitigate the levels of risk identified in respect of governance and management, protection, records and contracts of care. This response was accepted by the Chief inspector.

The registered provider was requested to detail the arrangements in place to effect their responsibilities as set out in the regulations. They were requested to immediately appoint a person to deputise as person in charge and submit the necessary details on the required notification.

The provider's response to an urgent compliance plan request to address the risk did provide assurance that the risk was adequately addressed and was accepted by the Chief Inspector.

The annual review of the quality and safety of the service for 2025 and quality improvement plan for 2026 was unavailable for review on the day of inspection.

Inspectors saw that the clinical nurse managers were endeavouring to complete audits and finalise the report.

Overall, the documents reviewed did not meet the legislative requirements including staff records and residents' contracts of care and will be discussed under the relevant regulation.

Regulation 15: Staffing

The registered provider did not ensure that the numbers of staff and skill-mix was appropriate having regard to the size and layout of the centre and the assessed needs of the residents. This was evidenced by:

- Clinical nurse managers were rostered for duty to compensate for staff nurse unavailability. The impact was that there were not enough nurse management to supervise care delivery. For example, staff were not aware of a recent court order decision by The District Court to appoint a said person to be the decision-making representative on behalf of a resident.
- Inspectors observed reduced staff nurses on night duty. During one night, there was one staff nurse allocated to the ground floor and one allocated to the first floor responsible for the care of a large number of residents. On occasions, one nurse had to assist with medication administration on the other floor. This arrangement was not appropriate and posed a risk to the safety of the residents. On day two of the inspection there was a deficit in healthcare staff overnight due to short notice absence. Staff on duty were unable to access agency staff to fill the healthcare vacancy.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training records were maintained to assist with monitoring and tracking completion of mandatory and other training completed by staff. A review of training records indicated that the majority of staff were up-to-date with mandatory training, with a small amount of staff, who were due refresher training, booked into upcoming dates.

Judgment: Compliant

Regulation 21: Records

The registered provider failed to ensure that the management of records was in line with regulatory requirements. For example;

- Residents' records were not kept in a safe manner on the ground floor. The filing cabinet which held the records was not securely locked which meant that residents, staff and visitors had unrestricted access to these records. Furthermore, persons not employed by the registered provider had unrestricted access to confidential information pertaining to residents.
- Records relating to newly admitted residents for example; consent for pictures or indication of wishes such as consent for hospital transfer were not fully recorded or signed by the resident and their representative.
- Staff personnel files were not in place for a number of people who worked in the centre. Where such files were available they did not all contain all the necessary information required by Schedule 2 of the regulations.

Documents as outlined in Schedule 2 and 4 were not held in respect for each person working in the centre, including:

- Vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. At least three persons were identified without a garda vetting in place.
- A full employment history, together with a satisfactory history of any gaps in employment.
- Correspondence, reports, records of disciplinary action and any other records in relation to his or her employment.
- Two written references, including a reference from the person's most recent employer.
- A record of all persons currently employed at the designated centre, including in respect of each person: the dates on which he or she commenced to be employed, the position he or she holds at the designated centre, the work that he or she performs and the copy of the duty roster of the persons working at the designated centre.

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. This impacted on effective governance and oversight of the service. The person in charge was on statutory leave for greater than 42 days and there were no deputising arrangements in place. Inspectors learned on the inspection that a company

director who was delegated by the provider for senior management oversight of the service had resigned. Furthermore, in the absence of the person in charge, the provider had not nominated a staff member, to the role of designated Safeguarding Officer, with responsibility for safeguarding oversight, reporting and compliance.Therefore there was a complete lack of clarity with regards to lines of authority and accountability in the centre.

- The provider had failed to ensure that robust processes were in place to manage the centre in the event of unplanned absences to ensure person-centred, effective and safe services.
- Staffing resources were not adequate as detailed under Regulation 15 and clinical nurse managers were covering the gaps in the rota to ensure residents' needs were met. This led to further depletion of management oversight. Those charged with responsibility for the day-to-day operation of the centre did not have the authority to secure agency staff to fill any vacancies.
- There was uncertainty within the centre regarding the appropriate and necessary number of staff required to effectively operate the designated centre and to ensure that residents care needs could be met. The provider was requested at the end of the inspection to submit an account of staff allocation for all staff since March 2025. This was not completed.
- The registered provider failed to ensure that equipment resources were adequate. For example, the oven in the centre was broken since the end of 2025 and there was no clear plan of action to repair or replace. The hoist with weighing capability was out of action with no plan to repair, impacting on the ability to keep track of some residents' weight.

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,

- The provider had failed to implement recruitment procedures in-line with the legislative requirements. This posed a significant risk to the safety and welfare of the residents.
- The provider failed to take all reasonable measure to protect residents from abuse namely, allowed personnel in the designated centre without having obtained a vetting disclosure with the National Vetting Bureau (Children and Vulnerable Persons) Act, 2012. An immediate action was issued to the provider on the first day of inspection.
- As a result of the depletion of governance and management structures, the supervision of staff practices was no longer effective. This adversely impacted the care the residents received which was not always in line with their assessed needs as further outlined under Regulation 5.
- The registered provider failed to notify the Chief inspector of changes to the governance structures and alternative arrangements to ensure continuity of oversight as further described under Regulation 32 and Regulation 33.
- In the absence of key leadership personnel, pre-admission assessments of residents were not appropriately completed and were not informed by the ability of the registered provider to access the resources required to meet the needs of those residents.

- Staff on duty had no access to systems to ensure that the service was effectively monitored. For example, staff did not have access to the complaints system and therefore had no access to complaints that may have been received. Staff on duty were not aware if the service was a pension-agent for any resident, however it was later confirmed that they were not.
- A review of the record management systems in the centre found that records were not managed in line with regulatory requirements as outlined in Regulation 21: Records.
- The general oversight of the physical environment was not robust. Persistent malodours were present in the centre. A bedroom window was damaged and there was no plan in place to repair or replace. Inspectors requested an up-to-date site survey report on the day of inspection.
- Oversight of fire precautions was not sufficient. A window bolted closed in a resident bedroom prevented an alternative means of escape in the event of a fire. Five oxygen cylinders stored unsecured in the pharmacy store room, posed a potential fire safety risk, and was a repeated finding from the previous inspection. The resident's evacuation list at main reception was not updated; this had potential to cause a serious confusion in the event of a fire due to inaccurate details available for the fire service, hampering the process of evacuating all residents in the centre and ensuring their safe placement. An immediate action was issued to the provider on day two inspection to ensure that all residents were protected from the risk of fire.
- The annual review of the quality and safety of care delivered to residents for 2025 or a quality improvement plan for 2026 was unavailable on the day of inspection.
- The registered provider did not ensure that there were effective arrangements in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to the residents. Staff's concerns were dismissed when they tried to raise awareness about the unsafe admissions into the centre.

An urgent action plan was requested the day following the inspection, which provided the required assurances.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The registered provider had failed to agree in writing with four newly admitted residents, on admission the terms of admission to the centre, the services to be provided and the fees to be charged for such services and any additional fees.

One of the new residents who spoke with the inspectors on the day said they felt it was unusual that they had not been asked to sign anything and did not really know the terms and conditions of residence.

An urgent action plan was requested the day following the inspection.

Judgment: Not compliant

Regulation 32: Notification of absence

The registered provider did not give the Chief Inspector written notice of the absence of the person in charge for a period of a continuous 42 days or more.

An urgent action plan was requested the day following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider did not provide an accessible and effective procedure for dealing with complaints. While residents and visitors were aware of the process for making a complaint, they were unclear about who specifically they should direct their complaint to.

No alternative arrangements had been made for the management of complaints in the absence of the person in charge, who was the designated complaints officer in the centre. Staff did not have access to the complaints system and therefore were not able to manage complaints in the event of unplanned absences.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations, however;

- The admissions policy in the centre incorrectly directed staff to complete the comprehensive assessment for new residents within a maximum of 14 days.

Judgment: Substantially compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

The registered provider did not give notice in writing to the Chief Inspector the deputising arrangements for the management of the designated centre or the procedures and arrangements in place for the running of the designated centre, during the absence of the person in charge.

Judgment: Not compliant

Quality and safety

Overall, this inspection found significant concerns in respect of the ability of the registered provider to oversee and provide a safe and quality service for the residents living in the centre, due to the ineffective governance arrangements, as detailed in the Capacity and Capability section of this report.

Significant action was required across most areas inspected against, as set out under Regulation 5: Individual assessment and care plan, Regulation 8: Protection, Regulation 9: Residents' rights, Regulation 17: Premises, Regulation 18: Food and Nutrition and Regulation 27: Infection control.

The inspectors viewed a sample of residents' assessments and care plans. An electronic system was in place since October 2025 and staff were still in the process of transferring care plans across to the new system. Overall, from the sample of care plans reviewed inspectors found that the content of care plans was not always accurate and updated to guide safe and effective care. These findings are presented under Regulation 5: Individual assessment and care plan.

Residents had access to general practitioners (GP) from a local practice, specialist services and health and social care professionals, such as gerontology, physiotherapy, dietitian and speech and language, as required. Residents had access to a mobile x-ray service referred by their GP which reduced the need for trips to hospital. Residents had access to local dental and pharmacy services.

The registered provider had a policy on the use of restraint and a restrictive practice register was in place. Residents who experienced responsive behaviours were observed to receive care and support from staff that was person-centred, respectful and non-restrictive. They had care plans and ABC (antecedent, behaviour, consequence) charts in place however, there was no evidence that the results and findings from these assessments were appropriately analysed and used for further interventions.

The registered provider had not ensured that all reasonable measures had been taken to protect residents from abuse. Inspectors found staff working in the centre who did not have a valid Garda vetting disclosure in place, references or contract of

employment. These and other findings are discussed further under Regulation 8: Protection.

While residents' nutritional and hydration needs were met, and health care professionals such as dietitians, were consulted if required, residents were not always offered choice at mealtimes.

Infection prevention and control (IPC) arrangements in the centre did not ensure the sustainable delivery of safe and effective infection prevention and control. For example, areas of the centre in use by residents were found to be unclean and will be detailed further in the report.

Regulation 17: Premises

Improvement was required of the registered provider, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example;

- The premises was not kept in a good state of repair internally and externally. Damp was evident in some resident bedrooms and works were in progress to apply a sealant externally to prevent moisture getting in through the wall. Appropriate ventilation was not in place in all areas of the designated centre; persistent malodours were present in the centre. A broken window in a resident's room on the ground floor was bolted in such that it could no longer be opened. This was part of an urgent action given to the provider on the day and satisfactory assurances were received following the inspection that corrective action was taken to address the window.
- Not all equipment for use by residents was in good working order. The oven was broken since end of 2025. A bedpan washer remained out-of-order on the first floor, as previously identified on the last inspection. The hoist with weighing capability was not working.
- Inappropriate storage was identified in some areas of the centre. Four hoists and a weighting chair were observed in a communal bathroom.
- A communal bathroom registered for the use of residents was locked with a keypad, which meant that residents could not access this facility without assistance from staff.

An immediate action plan was issued to the provider on day two inspection in respect of fire safety, and provider's response provided the required assurances.

Judgment: Not compliant

Regulation 18: Food and nutrition

The dietary needs of all residents was not met. This was evidenced by;

- Residents did not have choice in relation to how their food was prepared and cooked. The absence of an oven limited the menu options. Residents reported an over-reliance on fried foods. Beef on the menu on the day of inspection was not cooked as advertised as it had been boiled rather than roasted.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider did not ensure that infection prevention and control (IPC) procedures in relation to environmental hygiene and practices were consistent with the standards published by the authority and are implemented by staff.

- Areas of the kitchenette on the ground floor and equipment being used to serve residents was visibly unclean and required urgent attention for example; there was burnt food residue on the inside of the bain marie with an unpleasant malodour, the milk dispenser was unclean, tea and coffee dispensers were unclean and stained, plastic tumblers used by residents were stained and worn. A cupboard in the dining room was dirty and contained food debris.
- Hand hygiene facilities were not in line with best practice guidelines. Two hand hygiene sinks needed to be deep cleaned.
- The bed pan washer on the first floor was out of order for a prolonged period of time, as previously identified on the last inspection.
- Inspectors were not assured there was an IPC lead staff member appointed in the centre as this was unknown by staff when asked.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors found that for new residents a comprehensive assessment of need was not always completed within 48 hours of admission and consequently, appropriate care plans were not developed.

For example:

- A risk assessment had not been completed for a resident who was admitted to the centre and had a mental health diagnosis; consequently a care plan was not developed to guide staff on the most appropriate interventions to support the resident’s mood and behaviours.

- Care plans were not informed by an assessment of need and were generic for example: a resident who was wandering into other resident's rooms did not have this documented in their safeguarding care plan, and therefore no interventions were identified to support the resident.

Care plans were not clear and contained conflicting information. For example:

- No continence assessments were in place for residents who had an identified need in their care plan. Staff knowledge of residents' continence needs was inconsistent and inspectors found instances where residents who did not require continence wear were provided with pads. In the absence of evidence based assessments to inform care, there was a risk of task-based care which did not meet residents' needs.
- A resident with a pressure ulcer had a care plan in place which referred to strict repositioning on a two-hourly basis, however full records were not available for review and records that were available contained gaps. This did not provide assurance that residents' needs were consistently being met in these areas.
- Records did not support the care provided. Two residents whose care plans indicated that they were to be repositioned everyday did not have any evidence that this had been carried out. Staff informed the inspector this resident no longer required this and that the care plan should have been discontinued.
- Care plans directed staff to ensure mattresses were set to residents' weight however not all mattresses required this and specific instructions were not included to direct staff how to best guide care in this area. Inspectors were informed that the mattress settings were managed by an external company, however there was a lack of assurance that mattresses were correctly set as they were observed with a flashing light present. Furthermore the weighing hoist was broken.

Oversight of residents' care plans required improvement to ensure the centre was meeting the needs of each resident.

- A resident whose responsive behaviours were seen to be escalating over a period of a week as evidenced by the ABC (antecedent, behaviour, consequence) charts and whose behaviour was impacting on other residents had not been reviewed by the GP or gerontology. Inspectors were informed that this had been scheduled on day two of the inspection.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP). Residents also had access to a range of health and social care

professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life and palliative care.

Judgment: Compliant

Regulation 8: Protection

The registered provider failed to take all reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse in line with the National Policy for Safeguarding Vulnerable Person at Risk of Abuse 2014, as evidenced by:

- Staff were working in the centre without a Garda vetting disclosure in place, posing a risk to all residents.
- There was no safeguarding officer appointed in the absence of the person in charge. This was not in line with the registered provider's safeguarding policy
- An alleged incident that took place between a resident and staff member was documented only in the resident's progress notes: there was no evidence provided to inspectors that this incident had been fully investigated to identify learning and to ensure preventative measures were put in place, if required.
- Staff were unaware that a resident had a recent decision making representative appointed as this information had not been communicated to them.

An immediate action plan was issued to the provider on day one inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not ensure that each resident's rights were being upheld at all times, as evidenced by the following;

- Residents and visitors had not been consulted or informed in relation to changes in the designated centre. They expressed concern about the lack of information provided to them regarding changes to the management structure; in the absence of the person in charge they were unsure as to who was actually in charge of the centre.
- Residents had not being informed about works that was due to commence in an internal courtyard. Some residents described the negative experience and had to close the curtain to maintain their privacy.
- Residents were not afforded choice at mealtimes due the unavailability of an oven in the centre since end of December 2025.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 32: Notification of absence	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Woodlawn Manor Nursing Home OSV-0008662

Inspection ID: MON-0049651

Date of inspection: 23/02/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The Registered Provider acknowledges the findings of the inspection which identified that staffing numbers and skill-mix were not consistently appropriate to meet the assessed needs of residents and the operational requirements of the designated centre.

The Registered Provider recognises that the rostering of Clinical Nurse Managers (CNMs) to cover staff nurse deficits impacted on their supernumerary role and reduced governance, oversight, and supervision of care delivery. This contributed to gaps in communication and awareness among staff, including critical information such as legal decision-making arrangements for residents.

The Registered Provider also acknowledges that night-time staffing levels were insufficient in the day of inspection, with reduced staff nurse presence and reliance on cross-cover between floors. This arrangement did not ensure effective supervision or timely care delivery. Additionally, contingency arrangements for unplanned staff absence were not sufficiently robust, as evidenced by the inability to source agency staff at short notice.

Immediate corrective actions taken:
• A full review of staffing levels and skill-mix, aligned with the layout of the centre and residents' clinical dependencies across day and night shifts, has been undertaken by the Deputy PIC and Registered Provider Representative.
• CNMs are no longer rostered to cover staff nurse vacancies, and their supernumerary status has been reinstated to ensure effective clinical governance, supervision, and oversight of care delivery, except in exceptional circumstances.
• Minimum staffing levels per floor and shift have been established, ensuring an appropriate number of staff nurses and healthcare assistants are rostered to safely meet resident needs on each floor.
• A floor-specific nursing staff and healthcare assistants' allocation model has been implemented to ensure that each floor has dedicated staff, eliminating the need for cross-cover between floors.

• Immediate steps have been taken to fill vacant nursing and healthcare assistant posts, including active recruitment process.
• A temporary staffing contingency plan has been implemented, including engagement with approved agency providers to ensure availability of replacement staff at short notice.
• A structured daily handover process has been reinforced to ensure all staff are informed of relevant clinical, legal (including decision-making arrangements), and safeguarding information.
Further actions:
• A comprehensive dependency-based staffing assessment tool has been implemented and is reviewed weekly to align staffing levels with residents' assessed needs.
• A staffing contingency protocol is in place, outlining steps for redeployment, escalation, and emergency agency activation when deficits occur:
- Any staffing deficit is escalated immediately to the PIC / Deputy PIC or on-call management.
- The Registered Provider Representative is notified of significant staffing risks.
- Agency cover or internal redeployment is actioned without delay, supported by confirmed agency agreements with defined response times.
• An ongoing recruitment plan is in place to ensure sustainable staffing levels, including retention strategies and structured onboarding processes.
• Weekly review of staffing rosters is conducted by the PIC / Deputy PIC and Registered Provider Representative to ensure safe staffing levels and appropriate skill-mix.
• Monthly Governance meetings include staffing as a standing agenda item, with review of incidents, near misses, and staffing-related risks. Monthly audit reports on staffing, handovers, and agency usage are presented at these meetings.
• All CNMs and nursing staff have received refresher training on communication, escalation, and governance responsibilities, including awareness of legal and safeguarding information.
Monitoring and oversight:
• Daily staffing checks are completed by CNMs.
• Weekly staffing audits are conducted by the PIC / Deputy PIC and CNMs to ensure compliance with required staffing levels and skill-mix, with outcomes shared with the Registered Provider Representative.
• Monthly governance and compliance audits include review of staffing effectiveness and its impact on resident care.
• All staffing records, rosters, and escalation logs are maintained and available for HIQA inspection.
• Ongoing monitoring and tracking is maintained through the centre's Quality Improvement Plan, which evidences sustained compliance with Regulation 15 - Staffing and Regulation 23 - Governance and Management. Progress is reviewed at weekly and monthly Governance meetings, and actions are updated, closed, and re-audited to ensure sustained improvement.
Responsible person(s):
PIC / Deputy PIC, CNMs, Registered Provider Representative

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of recruitment and contingency measures: by 05/05/2026 and ongoing

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that staffing levels and skill-mix have been reviewed and strengthened to ensure they are appropriate to the size, layout, and assessed needs of residents. Robust governance, escalation, and contingency arrangements are now in place to ensure safe, effective, and consistent staffing at all times.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Registered Provider acknowledges the findings of the inspection which identified that records were not consistently managed in line with regulatory requirements, including issues relating to the security, completeness, and availability of resident and staff records.

The Registered Provider acknowledges that residents' records were not securely stored, resulting in unrestricted access to confidential information.

The Registered Provider also acknowledges that documentation for newly admitted residents was incomplete, including missing consents and signatures.

In addition, staff personnel files were not fully compliant with Schedule 2 requirements, including absence of Garda vetting, incomplete employment histories, missing references, and lack of a comprehensive staff register.
The Registered Provider recognizes that these deficits posed a risk to residents' privacy, dignity, and safety, and did not ensure compliance with legislative requirements.

Immediate corrective actions taken:
• All resident records have been secured in locked storage units, with restricted access in place to authorized staff only.
• Access to confidential information has been restricted and controlled, ensuring that residents, visitors, and unauthorized persons cannot access records.
• A full audit of all resident records has been completed to ensure that all required documentation, including consent forms and admission documentation, are completed, signed, and up to date.
• Any missing consent documentation (including consent for photographs and hospital transfer) has been obtained and appropriately recorded.
• A full audit of all staff personnel files has been undertaken against Schedule 2 requirements.
• Immediate action has been taken to ensure that no staff member is permitted to work without valid Garda vetting in place.
• Any gaps identified in staff files, including vetting disclosures, employment histories,

two written references (including from the most recent employer), contract, ID, qualifications, disciplinary records, and up-to-date rosters have been addressed and completed.
• A central staff register has been established, containing all required information including start dates, roles, duties, and current roster arrangements.

Further actions:
• Records management policy has been reviewed and strengthened, clearly outlining requirements for secure storage, access control, and documentation standards.
• A standardized admission documentation checklist has been implemented to ensure all required resident information, consents, and signatures are completed at the point of admission.
• A staff file compliance checklist aligned with Schedule 2 has been implemented and is used for all new and existing staff.
• A robust pre-employment verification process has been implemented, ensuring that:
- Garda vetting is received and verified prior to commencement.
- Two written references are obtained and validated.
- Full employment history, including explanation of gaps, is recorded.
- All required documentation is in place prior to any duties being undertaken.
• A document control system has been implemented to ensure records are maintained, reviewed, and updated in line with regulatory requirements.
• Staff have received training on Records management, Confidentiality, and GDPR requirements.

Monitoring and oversight:
• Filing cabinets containing personal records are now locked and signed off daily by the CNMs. Daily spot checks by CNMs to confirm secure storage of all files.
• Weekly audits of resident records and staff files are conducted by the PIC / Deputy PIC and CNMs to ensure compliance with Schedule 2 and Schedule 4 requirements.
• Monthly governance audits include review of records management practices, confidentiality, and documentation completeness.
• The staff register and personnel files are reviewed regularly by the Registered Provider Representative.
• Ongoing monitoring and tracking is maintained through the center’s Quality Improvement Plan, evidence sustained compliance with Regulation 21 - Records and Regulation 23 - Governance and Management.
• All records are maintained securely and are available for HIQA inspection.

Responsible person(s):
PIC / Deputy PIC, CNMs, Registered Provider Representative

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of records systems and verification processes by 05/05/2026

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that records management systems have been reviewed and strengthened. All records are now securely maintained, complete, and

compliant with regulatory requirements. Robust systems are in place to ensure confidentiality, accuracy, and ongoing compliance with Schedule 2 and 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:
The Registered Provider acknowledges the findings of the inspection which identified that governance and management systems were not sufficiently robust to ensure that adequate resources, effective oversight, and safe service delivery were maintained in line with the Statement of Purpose and full regulatory compliance within the designated center.

The Registered Provider acknowledges that:
• Governance structures were not maintained during the absence of the PIC, and deputizing arrangements were not in place.
• There was a lack of clarity regarding lines of authority, accountability, and safeguarding oversight.
• contingency arrangements for unplanned absences were not robust;
• staffing resources and management oversight were insufficient, resulting in CNMs being required to cover nursing shifts;
• systems were not in place to ensure effective recruitment, vetting, and safeguarding compliance;
• oversight of the environment, fire safety, equipment, records, and quality of care was not effective;
• statutory notifications were not submitted in line with regulatory requirements;
• systems to monitor the service, including complaints management and staff escalation pathways, were not accessible or effective;
• systems in place did not ensure consistent communication of key information to staff.
• pre-admission processes were not sufficiently robust to ensure safe admissions aligned with available resources.

The Registered Provider recognizes that these deficits resulted in a significant breakdown in governance, oversight, and risk management within the centre.

Immediate corrective actions taken:
• A revised governance and management structure has been implemented, clearly defining roles, responsibilities, reporting lines, and accountability.
• A Deputy PIC has been formally appointed on 23/02/2026, with clear deputizing arrangements in place to ensure continuous oversight in the absence of the PIC.
• Experienced Person in Charge has now been appointed. The PIC is scheduled to

commence in post on 05/05/2026.
• Established permanent deputizing arrangements for PIC and CNMs - Management Contingency Plan developed for any unplanned leave on 26/02/2026.
• A clearly defined deputizing and on-call management system is in place to ensure continuous management oversight at all times.
• A Designated Safeguarding Officer has been appointed with responsibility for safeguarding oversight, reporting, and compliance.
• The Registered Provider Representative has increased on-site presence and oversight, with scheduled visits and direct engagement with the management team.
• Weekly Governance meetings with documented minutes and tracked actions have been established, chaired by the Registered Provider Representative and attended by the PIC / Deputy PIC, CNMs and House Manager.
• A centre-wide risk assessment and service review has been completed, including staffing, safeguarding, fire safety, environment, equipment, and compliance systems.
• The centralized Risk register has been updated, with all risks graded, assigned, and actively monitored.

Immediate actions were taken to address key risks, including staffing, fire safety, documentation, IPC, and environmental issues.
• A structured communication system has been implemented, including daily clinical handovers and management updates to ensure all staff are informed of relevant clinical, legal, and operational matters.
• Fire safety risks addressed, including removal of obstructions, securing oxygen storage, and updating evacuation lists;
• Environmental issues addressed, including repair/replacement of damaged equipment (oven replaced on 19/02/2026 , hoist repaired/replaced on 23/02/2026, bedpan washer fully functional 05/05/2026) and maintenance actions initiated;
• Secure access to systems restored, including complaints management systems for staff;
• Once all inspection reports are reviewed and the admissions decision is made, they will be reviewed and controlled to ensure all admissions are aligned with available resources and that pre-admission assessments are completed appropriately..
• A full review of recruitment and vetting practices has been undertaken, with immediate action to ensure no staff member is working without full compliance with Schedule 2 requirements.
• Outstanding notifications to the Chief Inspector have been reviewed and submitted as required.
• A Quality Improvement Plan has been developed to address all areas of non-compliance identified during inspection.
Further actions:
• Governance systems have been strengthened to ensure:
- clear lines of authority and accountability at all times;
- continuous management oversight, including deputizing and on-call arrangements;
- all risks are identified, assessed, escalated, and monitored in a timely manner.
• A formal escalation and communication protocol has been implemented:
- staff can raise concerns through defined reporting pathways;
- all concerns are documented, reviewed, and acted upon;
- staff are supported to escalate concerns without fear of reprisal.
• A comprehensive audits plan has been implemented, including:

- weekly and monthly audits across key areas (staffing, care planning, IPC, safeguarding, fire safety, environment, records);
- audit findings informing governance decisions and improvement actions.
• A monthly governance report is prepared and reviewed by the Registered Provider, including:
- staffing levels and skill-mix
- incidents, risks, and safeguarding concerns
- audit outcomes and compliance status
- progress against the Quality Improvement Plan
• Staff training and awareness has been strengthened in relation to Governance, Communication, Safeguarding, and escalation procedures.
• A structured pre-admission assessment process has been strengthened to ensure that once all inspection reports are reviewed and the admission decision is made, the admissions are based on a full assessment of needs and available resources
• A preventative maintenance plan has been implemented for all equipment and the physical environment.
• A staff allocation and workforce planning system has been implemented, with full records maintained and available for inspection.
• An annual review of the Quality and Safety of Care for 2025 has been completed, and a Quality Improvement Plan for 2026 is in place.

Monitoring and oversight:
• Weekly Governance meetings with recorded minutes and tracked actions.
• Monthly Governance and Compliance audits, reviewed by the Registered Provider Representative.
• The Quality Improvement Plan is reviewed weekly, with actions updated, closed, and re-audited to ensure sustained compliance.
• The Risk register is actively maintained and reviewed, ensuring all risks are mitigated.
• The Registered Provider Representative maintains ongoing oversight through regular engagement, site visits, weekly and monthly Governance meetings and review of governance reports.
• All governance records, including audits, Risk register, and meeting minutes, are maintained and available for HIQA inspection.

Responsible person(s):
Registered Provider, Registered Provider Representative, PIC / Deputy PIC, CNMs, Designated Safeguarding Officer, House Manager

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of governance systems: 05/05/2026

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that governance and management systems have been comprehensively reviewed and significantly strengthened. A clear management structure, effective deputizing arrangements, and robust oversight systems are now in place to ensure that risks are identified, escalated, and managed appropriately.

Sufficient resources are now available to ensure the effective delivery of care in line with the Statement of Purpose. Systems are in place to ensure that risks are identified, escalated, and managed appropriately, and that the service is safe, consistent, and effectively monitored.

The Registered Provider has implemented effective governance processes to ensure that the service is safe, well-managed, and compliant with regulatory requirements, and that sustained compliance is maintained.

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:
The Registered Provider acknowledges the findings of the inspection which identified that written agreements outlining the terms of admission, services to be provided, and fees to be charged were not completed for four newly admitted residents at the time of admission.

The Registered Provider acknowledges that this resulted in residents not being fully informed of the terms and conditions of their residency, including services and associated fees, which is not in line with regulatory requirements.

Immediate corrective actions taken:
• Written contracts of care have now been completed, signed, and agreed with all residents identified during inspection and/or their representatives.
• Each contract clearly outlines:
- the terms of admission;
- the services to be provided;
- the fees to be charged, including any additional charges.
• Residents and/or their representatives were fully informed and given the opportunity to review and discuss the terms of the agreement prior to signing.
• A full audit of all resident contracts has been completed to ensure compliance across the centre.

Further actions:
• A standardized admission process and checklist has been implemented to ensure that no resident is admitted without a completed and signed Contract of care.
• Responsibility for verifying completion of contracts has been clearly assigned to the PIC / Deputy PIC and Administration team prior to finalizing any admission.
• A pre-admission and admission verification process has been strengthened to ensure that all required documentation, including contracts, is completed in advance or on the day of admission.
• Ongoing staff training has been provided to ensure awareness of regulatory

requirements relating to Contracts of care and Residents' rights.

Monitoring and oversight:
• Monthly audits of residents' contracts are conducted by the PIC / Deputy PIC to ensure all contracts are completed, signed, and up to date.
• Monthly governance audits include review of compliance with Regulation 24.
• Compliance with Contracts of care is monitored through the centre's Quality Improvement Plan, with actions tracked and reviewed at Governance meetings.
• All contracts are maintained securely and are available for HIQA inspection.

Responsible Person(s):
PIC / Deputy PIC, Admin, Registered Provider Representative

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of admission controls: Completed

Oversight / review frequency: Ongoing
The Registered Provider is satisfied that all residents now have a written contract of care in place in accordance with regulatory requirements. Robust systems have been implemented to ensure that all future admissions are supported by a completed and signed agreement, ensuring transparency, clarity, and protection of residents' rights at all times.

Regulation 32: Notification of absence	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of absence:
The Registered Provider acknowledges the findings of the inspection which identified that written notification was not submitted to the Chief Inspector regarding the absence of the Person in Charge (PIC) for a period exceeding 42 consecutive days.

The Registered Provider acknowledges that this was not in compliance with regulatory requirements and recognizes the importance of timely notification to ensure transparency and continuity of governance and oversight.

Immediate corrective actions taken:
• Notification of the absence of the Person in Charge has now been submitted to the Chief Inspector, in line with regulatory requirements.
• A Deputy PIC has been formally appointed on 23/02/2026, with clearly defined deputizing arrangements in place to ensure continuous management and clinical

oversight in the absence of the PIC.
• A Person in Charge has been appointed and is scheduled to commence in post on 05/05/2026. Formal notification will be submitted to HIQA in advance of the commencement date, in line with regulatory requirements.
• The Registered Provider Representative has ensured increased oversight and support to the Deputy PIC and management team during the period of PIC absence.

Further actions:
• A protocol has been implemented to ensure that all required statutory notifications are submitted within the required timeframes.
• Responsibility for submission of notifications has been clearly assigned to the Registered Provider Representative, with oversight by the PIC/Deputy PIC.
• A compliance checklist for regulatory notifications has been introduced to ensure that all obligations under Regulation 32 and related regulations are met.
• Governance systems have been strengthened to ensure that any future absence of the PIC is:
- formally documented;
- notified to the Chief Inspector within required timeframes;
- supported by clear deputizing arrangements.
Monitoring and oversight:
• Compliance with statutory notifications is reviewed at Governance meetings.
• A monthly audit of notifications and regulatory compliance is undertaken by the Registered Provider Representative.
• All notifications and correspondence with the Chief Inspector are recorded, tracked, and available for inspection.
• Ongoing monitoring is maintained through the center's Quality Improvement Plan, evidencing sustained compliance with Regulation 32 and Regulation 23 - Governance and Management.

Responsible Person(s):
Registered Provider, Registered Provider Representative, PIC / Deputy PIC

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of notification procedures: Completed

Oversight / review frequency: Ongoing
The Registered Provider is satisfied that appropriate systems are now in place to ensure that all required notifications, including notification of absence of the Person in Charge, are submitted in line with regulatory requirements. Clear accountability, oversight, and monitoring arrangements are in place to ensure ongoing compliance.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Registered Provider acknowledges the findings of the inspection which identified that the complaints procedure in the designated center was not fully accessible or effective.

The Registered Provider acknowledges that, while residents and visitors were aware of how to make a complaint, there was a lack of clarity regarding the designated person to receive complaints. In addition, no alternative arrangements were in place during the absence of the Person in Charge (PIC), who was the nominated Complaints Officer. Staff did not have access to the complaints system and were therefore unable to manage complaints in the event of unplanned absences.

The Registered Provider recognizes that this did not ensure an accessible, transparent, and effective complaints management process.

Immediate corrective actions taken:
• A revised complaints management structure has been implemented.
• A Deputy PIC has been formally assigned as Complaints Officer in the absence of the PIC, with clearly defined roles and responsibilities.
• An additional nominated person/CNM has been identified to oversee complaints, ensuring independence and appropriate review.
• The Complaints procedure has been updated and clearly displayed in accessible areas throughout the center, including clear details of:
- who to direct complaints to;
- how complaints can be made;
- expected timeframes for response.
• All staff now have access to the complaints system and records, enabling them to appropriately manage and escalate complaints.
• Residents and their representatives have been informed of the updated complaints process, including named contact persons.
Further actions:
• A formal complaints management protocol has been implemented to ensure:
- all complaints are documented, acknowledged, investigated, and responded to in line with regulatory requirements;
- clear escalation pathways are followed where required.
- A complaints log and tracking system has been strengthened to ensure all complaints are recorded and monitored through to resolution.
• Staff have received training on Complaints management, including their roles and responsibilities in receiving, escalating, and documenting complaints.
• Complaints management has been incorporated into governance and oversight systems, ensuring that:
- complaints trends are analyzed;
- learning from complaints informs service improvement.

Monitoring and oversight:
• Weekly review of complaints by the PIC / Deputy PIC
• Monthly governance audits include review of complaints management, response times, and outcomes.
• Complaints are tracked through the center’s Quality Improvement Plan, with actions

reviewed and closed at Governance meetings.
• All complaints records are maintained securely and are available for HIQA inspection.

Responsible person(s):
PIC / Deputy PIC (Complaints Officer in absence of PIC), CNMs, Registered Provider Representative

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of complaints systems: 05/05/2026

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that the complaints procedure is now accessible, clearly defined, and effectively implemented. Residents, visitors, and staff are aware of how and to whom complaints should be made. Robust systems are in place to ensure that all complaints are managed in a timely, transparent, and effective manner, with appropriate oversight and continuous improvement.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Registered Provider acknowledges the findings of the inspection which identified that, while policies and procedures were in place as required under Schedule 5, the admissions policy contained incorrect guidance regarding the timeframe for completion of comprehensive assessments for newly admitted residents.

The Registered Provider acknowledges that the policy incorrectly referenced a timeframe of up to 14 days, which is not aligned with regulatory requirements and best practice.

Immediate corrective actions taken:
• The Admission Policy has been reviewed and amended to reflect the correct requirement that a comprehensive assessment is completed prior to admission, in line with regulatory requirements.
• The updated policy has been approved and implemented within the centre.
• All relevant staff have been informed of the corrected requirement, ensuring that assessments are completed prior to admission.

Further actions:
• A full review of all policies and procedures commenced to ensure alignment with current legislation, regulations, and best practice.

• A policy control system has been implemented to ensure all policies are:
- regularly reviewed;
- updated in line with regulatory requirements;
- version-controlled and approved.
• Staff have received refresher training on admission processes and regulatory requirements, including the requirement for pre-admission assessment.

Monitoring and oversight:
• Compliance with the admissions process is monitored through audit of pre-admission assessments by the PIC / Deputy PIC.
• Policy compliance is reviewed through monthly governance audits.
• Policies are included in the center's Quality Improvement Plan, with review schedules tracked and monitored.
• All policies are maintained and available for HIQA inspection.
Responsible person(s):
Registered Provider, Registered Provider Representative, PIC / Deputy PIC

Timeframe / completion date:
Immediate corrective actions: Completed
Full Admission policy review and implementation: Completed
A full review of all policies and procedures by 15/06/2026

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that the Admissions policy has been corrected and is now fully aligned with regulatory requirements. Systems are in place to ensure that all policies and procedures remain accurate, up to date, and reflective of current legislation and best practice.

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Not Compliant

Outline how you are going to come into compliance with Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre:
The Registered Provider acknowledges the findings of the inspection which identified that written notification was not submitted to the Chief Inspector outlining the deputizing arrangements and management procedures in place during the absence of the Person in Charge (PIC).

The Registered Provider acknowledges that this was not in compliance with regulatory requirements and recognizes the importance of ensuring that clear arrangements for the

management and oversight of the designated center are formally communicated to the Chief Inspector.

Immediate corrective actions taken:
• Notification has now been submitted to the Chief Inspector, detailing the deputizing arrangements in place during the absence of the Person in Charge.
• A Deputy PIC has been formally appointed, with clearly defined roles and responsibilities to ensure continuity of management and clinical oversight.
• Clear management and reporting structures have been established and communicated to all staff.
• The Registered Provider Representative has ensured increased oversight and support for Deputy PIC and management team during the absence of PIC.

Further actions:
• A protocol for statutory notifications has been implemented to ensure all notifications required under Regulation 33 are submitted within the required timeframes.
• Responsibility for submission of such notifications has been clearly assigned to the Registered Provider Representative, with oversight by the PIC / Deputy PIC.
• A compliance checklist for regulatory notifications has been introduced to ensure that all obligations under Regulation 32 and Regulation 33 are met.
• Governance systems have been strengthened to ensure that, in any future absence of the PIC:
- deputizing arrangements are clearly defined and documented;
- notification is submitted to the Chief Inspector without delay;
- appropriate management oversight is maintained at all times.
Monitoring and oversight:
• Compliance with statutory notifications is reviewed at Governance meetings.
• A monthly audit of regulatory notifications is undertaken by the Registered Provider Representative.
• All notifications and related correspondence are recorded, tracked, and available for inspection.
• Ongoing monitoring is maintained through the center's Quality Improvement Plan, evidencing sustained compliance with Regulation 33 and Regulation 23 - Governance and Management.

Responsible person(s):
Registered Provider, Registered Provider Representative, PIC / Deputy PIC

Timeframe / completion date:
- Immediate corrective actions: Completed
- Full implementation of notification protocol: Completed

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that appropriate systems are now in place to ensure that deputizing arrangements and management procedures are clearly defined and notified to the Chief Inspector in line with regulatory requirements. Robust governance and oversight arrangements are in place to ensure ongoing compliance.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider acknowledges the findings of the inspection which identified that the premises did not fully conform to the requirements of Schedule 6 of the regulations, including issues relating to maintenance, ventilation, equipment, storage, and accessibility.

The Registered Provider acknowledges that areas of the center were not maintained in a good state of repair, including the presence of damp, inadequate ventilation, and persistent malodors. The Registered Provider also acknowledges that not all equipment was in good working order and that inappropriate storage practices and restricted access to a communal bathroom did not support residents' comfort, dignity, or independence.

Immediate corrective actions taken:
• Immediate actions were taken to address fire safety risks, in line with the urgent action issued, and satisfactory assurances were provided to HIQA.
• The damaged bedroom window has been repaired, restoring safe use and ventilation.
• External remedial works have been undertaken to address damp, including sealing works to prevent moisture ingress.
• A review of ventilation across the centre has been completed, and immediate measures implemented to improve airflow and reduce malodours.
• The oven has been replaced, ensuring full restoration of kitchen functionality.
• The hoist with weighing capability has been repaired/replaced and is now in full working order.
• The bedpan washer has been checked, missing parts ordered and fully functional by 05/05/2026, ensuring appropriate infection control practices are supported.
• All inappropriate storage has been addressed, and equipment has been relocated to designated storage areas.
• The communal bathroom has been made accessible to residents, with keypad restrictions removed or appropriate access arrangements put in place to ensure residents' independence and dignity.

Further actions:
• A preventative maintenance plan has been implemented, covering:
- routine inspection of the building fabric;
- servicing and maintenance of all equipment;
- prompt identification and resolution of defects.
• A scheduled Environmental audit has been introduced to ensure ongoing compliance with Schedule 6 requirements.
• A review of storage systems has been completed to ensure all equipment is stored safely and appropriately.
• A ventilation and environmental control plan has been implemented to ensure adequate

airflow and elimination of malodors.
• All staff have been reminded of their responsibilities in relation to environmental safety, cleanliness, and reporting of maintenance issues.

Monitoring and oversight:
• Daily environmental checks are completed by House Manager and housekeeping supervisor.
• Weekly environmental audits are conducted by the PIC / Deputy PIC, CNMs and House Manager.
• Monthly governance audits include review of premises, maintenance, and equipment.
• Maintenance logs and service records are maintained and reviewed regularly.
• Ongoing monitoring and tracking is maintained through the center's Quality Improvement Plan, evidencing sustained compliance with Regulation 17 - Premises and Regulation 23 - Governance and Management.
• All records are maintained and available for HIQA inspection.

Responsible person(s):
Registered Provider Representative, PIC / Deputy PIC, CNMs, House Manager and Maintenance Personnel

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of maintenance and environmental systems: 05/05/2026

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that the premises and equipment have been reviewed and brought to an appropriate standard in line with Schedule 6 requirements. Systems are now in place to ensure that the environment is safe, well-maintained, and suitable to meet the needs of residents, and that ongoing compliance is sustained through effective governance and oversight.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The Registered Provider acknowledges the findings of the inspection which identified that residents' dietary needs and preferences were not fully met, and that choice in relation to food preparation and menu options was limited.

The Registered Provider acknowledges that the absence of a functioning oven significantly impacted the variety and quality of meals provided, resulting in an over-reliance on fried and alternative cooking methods. The Registered Provider also

acknowledges that meals were not always prepared in line with the advertised menu, which impacted on residents' expectations, choice, and overall dining experience.

The Registered Provider recognises that this did not support person-centred care or residents' rights in relation to choice, dignity, and quality of life.

Immediate corrective actions taken:
• The oven has been replaced, restoring full cooking capacity within the centre.
• The menu has been reviewed and reinstated, ensuring that meals are prepared and served as advertised.
• Residents are now provided with choice at each mealtime, including alternative options where required.
• A review of residents' dietary preferences and needs has been completed to ensure meals are aligned with individual requirements.
• Catering staff have been briefed on the importance of providing choice, variety, and consistency with menu plans.

Further actions:
• A revised menu planning system has been implemented, ensuring:
- a varied, balanced, and nutritious menu;
- inclusion of residents' preferences and feedback;
- meals prepared in line with menu descriptions.
• A resident consultation process has been strengthened, including:
- regular resident meetings;
- feedback on meals and menu choices;
- ongoing engagement with residents and their representatives.
• A food and nutrition audit programme has been implemented to monitor:
- quality and variety of meals;
- adherence to menus;
- resident satisfaction.
• Catering and care staff have received refresher training on Nutrition, Hydration, and person-centred mealtime practices.
Monitoring and oversight:
• Daily oversight of meal provision by the CNMs.
• Weekly review of menus and resident feedback by the PIC / Deputy PIC.
• Monthly audits of food and nutrition practices, including menu compliance and resident satisfaction.
• Food and nutrition is included as a standing agenda item at Governance meetings.
• Ongoing monitoring and tracking is maintained through the centre's Quality Improvement Plan, evidencing sustained compliance with Regulation 18 - Food and Nutrition and Regulation 23 - Governance and Management.
• All records are maintained and available for HIQA inspection.

Responsible person(s):
PIC / Deputy PIC, Head Chef, Registered Provider Representative

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of menu and monitoring systems: 05/05/2026

Oversight / review frequency: Ongoing
The Registered Provider is satisfied that residents' dietary needs and preferences are now met in line with regulatory requirements. Residents are provided with appropriate choice, variety, and quality of meals, and systems are in place to ensure that food and nutrition standards are consistently maintained and monitored.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The Registered Provider acknowledges the findings of the inspection which identified that Infection prevention and control (IPC) procedures were not consistently implemented in line with national standards, particularly in relation to environmental hygiene, equipment cleanliness, and governance of IPC practices.

The Registered Provider acknowledges that areas of the center, including the kitchenette, dining equipment, and storage areas, were not maintained to the required hygiene standards.

The Registered Provider also acknowledges deficits in hand hygiene facilities, lack of functioning equipment (bedpan washer), and absence of clear IPC leadership within the center.

The Registered Provider recognizes that these deficits posed a risk to residents' safety and did not ensure the delivery of safe and effective care.

Immediate corrective actions taken:
• A deep cleaning plan has been completed across the center, including all kitchenettes, dining areas, and associated equipment.
• All food service equipment (Bain marie, milk dispensers, tea/coffee dispensers) has been thoroughly cleaned, sanitized, and brought to an appropriate standard.
• Plastic tumblers have been replaced with suitable, hygienic alternatives.
• All storage areas and cupboards have been cleaned, decluttered, and reorganized to ensure compliance with hygiene standards.
• Identified hand hygiene sinks have been deep cleaned and brought into compliance with best practice guidelines.
• The bedpan washer has been checked, parts ordered and it will be fixed and fully operational by 05/05/2026.
• An Infection Prevention and Control (IPC) Lead has been formally appointed, with responsibility for oversight, monitoring, and implementation of IPC practices.
• All staff have been reminded of IPC standards and cleaning responsibilities, with immediate reinforcement of expected practices.
Further actions:

• A comprehensive IPC programme has been implemented to ensure:
- adherence to national IPC standards;
- clear roles and responsibilities for all staff;
- consistent implementation of cleaning and hygiene practices.
• A cleaning schedule and accountability system has been introduced for all areas, including kitchenettes, dining areas, and equipment.
• A regular equipment maintenance and hygiene check system has been implemented to ensure all equipment remains clean and functional.
• Staff have received refresher training in IPC, hand hygiene, and environmental cleaning standards.
• The IPC Lead is responsible for:
- conducting regular audits;
- providing guidance and support to staff;
- ensuring compliance with HIQA and national IPC standards.

Monitoring and oversight:
• Daily environmental and hygiene checks are completed by CNMs and House Manager.
• Weekly IPC audits are conducted by the IPC Lead, PIC / Deputy PIC.
• Monthly governance audits include review of IPC compliance, environmental hygiene, and infection risks.
• IPC is included as a standing agenda item at Governance meetings.
• Ongoing monitoring and tracking is maintained through the center's Quality Improvement Plan, evidencing sustained compliance with Regulation 27 - Infection Prevention and Control and Regulation 23 - Governance and Management.
• All records, including cleaning schedules, audit reports, and training records, are maintained and available for HIQA inspection.
Responsible person(s):
PIC / Deputy PIC, IPC Lead, CNMs, House Manager, Housekeeping and Catering Staff, Registered Provider Representative

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of IPC systems and training: 15/06/2026

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that Infection prevention and control systems have been reviewed and strengthened. The environment and equipment are now maintained to an appropriate hygiene standard, and clear leadership, accountability, and monitoring systems are in place to ensure sustained compliance with IPC requiremen

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:
The Registered Provider acknowledges the findings of the inspection which identified that comprehensive assessments were not consistently completed within 48 hours of admission and that care plans were not always developed, accurate, or reflective of residents' assessed needs.

The Registered Provider acknowledges that:
• Risk assessments and care plans were not consistently completed for newly admitted residents;
• Care plans were at times generic and not informed by individual assessments and person-centered;
• Care plans contained conflicting or outdated information;
• Documentation did not always evidence that care was delivered as planned;
• Oversight of care planning systems was not sufficiently robust;
• Escalation of changing clinical needs was not always timely.

The Registered Provider recognizes that these deficits posed a risk to the delivery of safe, person-centered care.

Immediate corrective actions taken:
• A full review of all resident assessments and care plans has been completed to ensure they are:
- Individualized, person-centered;
- reflective of current needs;
- accurate and up to date.
• All newly admitted residents now have comprehensive assessments completed within 48 hours, with corresponding care plans in place.
• Specific actions have been taken in relation to identified deficits:
- Risk assessments and care plans have been developed for residents with mental health needs and responsive behaviors;
- Safeguarding care plans have been updated to reflect behaviors such as wandering and associated risks;
- Continence assessments have been completed, ensuring appropriate and evidence-based care is provided;
- Pressure ulcer care plans have been reviewed, with clear repositioning schedules and documentation requirements in place;
- Repositioning records have been reviewed and completed, and care plans updated where no longer required;
- Mattresses management has been reviewed, with confirmation of appropriate settings and clear guidance provided to staff.
• The weighing hoist has been repaired/replaced, ensuring accurate monitoring of residents' weight and appropriate equipment use.
• Residents with changing or escalating needs have been reviewed by relevant healthcare professionals (e.g. GP, gerontology), with care plans updated accordingly.

Further actions:
• A structured care planning system has been implemented to ensure:

- all assessments are completed within required timeframes;
- care plans are developed based on assessed needs;
- care plans are person-centered, specific, and outcome-focused.

• A care plan audit tool has been implemented to ensure:
- consistency between assessment, care plan, and daily records;
- accuracy and clarity of documentation;
- timely review and updating of care plans.

• A clear escalation protocol has been established to ensure that any change in a resident's condition is:
- identified promptly;
- reviewed by appropriate healthcare professionals;
- reflected in updated care plans.

• Staff have received refresher training on Assessment, Care planning, documentation, and person-centered care.

• The electronic care planning system has been fully checked and validated, ensuring all care plans are transferred, reviewed, and actively used in practice.

Monitoring and oversight:

• Daily review of care delivery by the CNMs.

• Weekly audits of assessments, care plans, and associated documentation by the PIC / Deputy PIC and CNMs.

• Monthly governance audits include review of care planning quality, documentation, and clinical outcomes.

• Care planning is included as a standing agenda item at Governance meetings.

• Ongoing monitoring and tracking is maintained through the center's Quality Improvement Plan, evidencing sustained compliance with Regulation 5 - Assessment and Care Planning and Regulation 23 Governance and Management.

• All records are maintained and available for HIQA inspection.

Responsible person(s):
PIC / Deputy PIC, CNMs, Registered Provider Representative

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of care planning systems and audits: 05/05/2026

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that assessment and care planning processes have been reviewed and strengthened. All residents now have comprehensive, individualized, person-centered and up-to-date assessments and care plans in place. Robust systems are in place to ensure that care is evidence-based, consistently delivered, and responsive to residents' changing needs.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Registered Provider acknowledges the findings of the inspection which identified that not all reasonable measures were taken to protect residents from abuse and that safeguarding systems were not fully effective or implemented in line with the National Policy for Safeguarding Vulnerable Persons at Risk of Abuse (2014).

The Registered Provider acknowledges that:
• staff were permitted to work in the center without Garda vetting in place;
• there was no designated Safeguarding Officer during the absence of the Person in Charge (PIC);
• safeguarding incidents were not consistently reported, investigated, or managed in line with policy;
• critical safeguarding information, including legal decision-making arrangements, was not effectively communicated to staff.

The Registered Provider recognizes that these deficits posed a serious risk to residents' safety and welfare and did not ensure effective safeguarding systems.

Immediate corrective actions taken:
• Immediate action was taken to ensure that no staff member is permitted to work in the center without valid Garda vetting in place. Any staff identified without full compliance were immediately removed from duty until all requirements were met.
• A full audit of all staff personnel files has been completed to ensure compliance with Schedule 2 requirements, including Garda vetting, references, and employment history.
• A Designated Safeguarding Officer has been formally appointed, with clear responsibility for safeguarding oversight, reporting, and compliance.
• All staff have been informed of safeguarding procedures, including reporting requirements and escalation pathways.
• The safeguarding incident identified during inspection has been reviewed and fully investigated, with appropriate actions taken, learning identified, and preventative measures implemented.
• Systems have been implemented to ensure that all safeguarding concerns are documented, reported, investigated, and notified in line with regulatory requirements.
• A communication process has been implemented to ensure that all staff are informed of critical resident information, including legal decision-making representatives and safeguarding risks.

Further actions:
• A robust safeguarding framework has been implemented to ensure:
- zero tolerance of abuse;
- full compliance with safeguarding policy and national standards;
- clear accountability for safeguarding at all levels.
• A pre-employment compliance system has been strengthened to ensure that:
- Garda vetting is completed and verified prior to any staff commencing work;
- all Schedule 2 documentation is in place before employment;
- non-compliance results in immediate escalation and removal from duty.
• A safeguarding training has been delivered to all staff, including:

- recognizing and responding to abuse;
- reporting and escalation procedures;
- residents' rights and protection.

• A safeguarding audit tool has been implemented to monitor:
- compliance with safeguarding procedures;
- documentation and reporting of incidents;
- effectiveness of safeguarding interventions.

• A clear escalation pathway has been implemented to ensure that:
- all safeguarding concerns are escalated immediately to the Safeguarding Officer, PIC/Deputy PIC, and Registered Provider Representative;
- all required notifications are submitted to the Chief Inspector without delay.

Monitoring and oversight:
• Daily oversight of safeguarding practices by the CNMs.
• Weekly safeguarding audits conducted by the Safeguarding Officer, CNMs and PIC / Deputy PIC.
• Monthly governance audits include review of safeguarding incidents, trends, and compliance.
• Safeguarding is a standing agenda item at Governance meetings.
• Ongoing monitoring and tracking is maintained through the center's Quality Improvement Plan, evidencing sustained compliance with Regulation 8 - Protection and Regulation 23 - Governance and Management.
• All safeguarding records, investigations, and notifications are maintained and available for HIQA inspection.

Responsible person(s):
Registered Provider, Registered Provider Representative, PIC / Deputy PIC, Designated Safeguarding Officer, CNMs, all staff

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of safeguarding systems and training: 05/05/2026

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that safeguarding systems have been comprehensively reviewed and strengthened. Robust measures are now in place to protect residents from abuse, ensure full compliance with safeguarding requirements, and promote a culture of safety, accountability, and zero tolerance of abuse within the center.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Registered Provider acknowledges the findings of the inspection which identified that residents’ rights were not consistently upheld, particularly in relation to communication, consultation, privacy, and choice.

The Registered Provider acknowledges that residents and visitors were not adequately informed or consulted regarding changes within the designated center, including changes to the management structure. This resulted in uncertainty regarding leadership and oversight. The Registered Provider also acknowledges that residents were not informed in advance of works taking place in the internal courtyard, which impacted on their privacy and overall experience. In addition, residents were not afforded appropriate choice at mealtimes due to limitations in catering equipment.

The Registered Provider recognizes that these deficits did not support residents’ rights to information, participation, dignity, and choice.
Immediate corrective actions taken:
• Residents and their representatives have been informed of the current management structure, including clear identification of the new Registered Provider Representative and Deputy PIC, and key contacts within the center.
• A communication system has been implemented, ensuring that all significant changes within the center are clearly communicated to residents and families in a timely manner.
• Residents have been informed of any planned works, including potential impact on their environment, with measures in place to maintain privacy and comfort.
• The oven has been replaced, restoring full cooking capacity and enabling provision of appropriate choice at mealtimes.
• Residents are now provided with choice at each mealtime, including alternative options in line with their preferences.

Further actions:
• A resident consultation framework has been strengthened, including:
- regular resident meetings;
- opportunities for residents and families to provide feedback;
- documentation and follow-up of issues raised.
• A communication protocol has been implemented to ensure:
- all changes in management, environment, or service delivery are communicated in advance;
- residents and families are kept informed in an accessible and timely manner.
• A privacy and dignity approach has been reinforced, ensuring:
- residents are supported to maintain privacy during any works or environmental changes;
- individual preferences are respected at all times.
• Staff have received refresher training on Residents’ rights, Communication, and Person-centered care.

Monitoring and oversight:
• Daily oversight of residents’ experience by the CNMs.
• Weekly review of resident feedback and concerns by the PIC / Deputy PIC.
• Monthly governance audits include review of residents’ rights, communication, and satisfaction.

• Residents’ rights are included as a standing agenda item at governance meetings.
• Ongoing monitoring and tracking is maintained through the center’s Quality Improvement Plan, evidenced sustained compliance with Regulation 9 (Residents’ Rights) and Regulation 23 (Governance and Management).
• Records of resident meetings, feedback, and actions taken are maintained and available for HIQA inspection.
Responsible person(s):
PIC / Deputy PIC, CNMs, Registered Provider Representative

Timeframe / completion date:
Immediate corrective actions: Completed
Full implementation of communication and consultation systems: 05/05/2026.

Oversight / review frequency: Ongoing

The Registered Provider is satisfied that residents’ rights are now upheld through improved communication, consultation, and person-centered care practices. Residents are informed, involved, and supported in decisions affecting their care and daily lives, and systems are in place to ensure that dignity, privacy, and choice are consistently promoted and maintained.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	05/05/2026
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	Orange	05/05/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	05/05/2026

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 the Chief Inspector.	Not Compliant	Red	23/02/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	05/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	23/02/2026
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	Red	23/02/2026
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for	Not Compliant	Red	23/02/2026

	key management roles in place.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	23/02/2026
Regulation 23(1)(e)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	05/05/2026
Regulation 23(1)(f)	The registered provider shall ensure that the review referred to in subparagraph (e) is prepared in consultation with residents and their families.	Not Compliant	Orange	05/05/2026
Regulation 23(1)(g)	The registered provider shall ensure that a copy of the review referred to in subparagraph (e)	Not Compliant	Orange	05/05/2026

	is made available to residents and, if requested, to the Chief Inspector.			
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e).	Not Compliant	Orange	05/05/2026
Regulation 23(2)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Red	23/02/2026
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, 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	Not Compliant	Red	23/02/2026

	reside in that centre.			
Regulation 24(2)(a)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.	Not Compliant	Red	23/02/2026
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Not Compliant	Red	23/02/2026
Regulation 24(2)(c)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of where appropriate, the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the arrangements	Not Compliant	Red	23/02/2026

	for the payment or refund of monies.			
Regulation 24(2)(d)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the resident is not entitled under any other health entitlement.	Not Compliant	Red	23/02/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Orange	15/06/2026
Regulation 32(1)	Where the person in charge of the designated centre proposes to be absent from the designated centre for a continuous period of 42 days or more, the registered provider shall give notice in writing to the Chief	Not Compliant	Orange	23/02/2026

	Inspector of the proposed absence.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	05/05/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	05/05/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly	Not Compliant	Orange	05/05/2026

	recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	16/06/2026
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	05/05/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	05/05/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment	Not Compliant	Orange	05/05/2026

	referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	05/05/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	23/02/2026
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	05/05/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	05/05/2026

Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	05/05/2026
Regulation 33(1)	Where the registered provider gives notice of the absence of the person in charge from the designated centre under Regulation 32, such notice shall include details of the deputising arrangements that will be in place for the management of the designated centre during that absence up to a 6 month period of time.	Not Compliant	Orange	23/02/2026
Regulation 33(3)(a)	The notice referred to in paragraph (1) shall specify the arrangements which have been, or were made, for the running of the designated centre during that absence.	Not Compliant	Orange	23/02/2026
Regulation 33(3)(b)	The notice referred to in paragraph (1) shall specify the deputising arrangements that have been made, or are proposed to	Not Compliant	Orange	23/02/2026

	be made, for the management of the designated centre during that absence, including the proposed date by which the deputising arrangements are or will be in place.			
Regulation 33(3)(c)	The notice referred to in paragraph (1) shall specify the name, contact details and qualifications of the person who will be or was deputising for the person in charge during that absence.	Not Compliant	Orange	23/02/2026