



**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:	Fearna Manor Nursing Home
Name of provider:	Genesis Healthcare Castlerea Limited
Address of centre:	Tarmon Road, Castlerea, Roscommon
Type of inspection:	Unannounced
Date of inspection:	19 June 2026
Centre ID:	OSV-0000339
Fieldwork ID:	MON-0049700

About the designated centre

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

The centre is a purpose-built facility, a single-storey building that is registered to accommodate a maximum of 30 dependent persons aged 18 years and over. It is situated in a residential area a short drive from the town of Castlerea. Bedroom accommodation consists of 30 single rooms all with en-suite facilities. There is a range of communal areas where residents can sit together and socialise. Other facilities include a dining area and spaces for visitors and people who smoke. There are toilets and bathrooms located near to communal areas. There are two outdoor areas that are easily accessible to residents. The centre caters for male and female residents who require long-term care and also provides care to people who have respite, convalescence, dementia or palliative care needs. In the statement of purpose, the provider states that they are committed to enhancing the quality of life of residents by providing a homely, safe and caring environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26
--	----

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 19 June 2026	09:15hrs to 17:15hrs	Michael Dunne	Lead
Friday 19 June 2026	09:15hrs to 17:15hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

This unannounced inspection was completed over one day. Overall the inspectors observed that residents were supported by a team of staff who were caring and kind. Residents spoke positively about their experience of living in the centre. One resident described the nursing home as "like a close-knit community where everyone is treated like family." However, some residents identified areas where improvements could be made. For example, one resident expressed disappointment that comfortable seating had been removed from the reception area, and replaced with office-style chairs. Another resident stated that daily newspapers were not routinely available in the centre, although staff would purchase a newspaper from the local shop on request.

The inspectors met with three visitors during the inspection. Visitors expressed a high level of satisfaction with the quality of care provided to their relatives and friends. They reported positive interactions with both the management team and staff. Visitors said that management were approachable and responsive, and that any questions or concerns raised were addressed in a timely manner.

Notwithstanding the positive feedback received from residents and visitors, the inspectors found that there were several areas where actions were required to improve the care and welfare of residents. A number of substantial and non-compliance's were found on this inspection. The areas in particular that required additional focus and oversight are discussed under the relevant regulations, and under the themes of Quality and Safety, and Capacity and Capability.

Upon arrival at the designated centre, the inspectors were met by a clinical nurse manager (CNM), and following a request for documentation to support the inspection process, the inspectors commenced a walk around the centre where they had the opportunity to meet and chat with residents and staff members. Inspectors were informed that the person in charge was on annual leave on the day of the inspection. Following the walk around the centre, the inspectors held an introductory meeting with the clinical nurse manager (CNM), and a member of the senior management team who had arrived to assist with the inspection process. The inspectors discussed the purpose of the inspection, and provided feedback on their observations and findings from the walk around the designated centre.

The inspectors found that staff were knowledgeable about residents' needs, and that they promoted and respected residents' rights and choices. The inspectors observed numerous friendly, compassionate, warm and respectful interactions between residents and staff throughout the day of the inspection. Residents were seen to be relaxed and comfortable in the company of staff.

Staff were observed assisting residents with their care needs throughout the day, as well as supporting them to mobilise to various communal areas within the building.

Observations confirmed that residents' requests for support were met by timely responses from the staff team. Some residents were observed having their breakfast in the dining room while other residents chose to have their breakfast in the main activity room. Several residents who presented with communication needs were afforded time and space to make their views known by the staff team present. Residents who expressed a view said that they felt safe in the centre, and should they have a concern, they could tell any member of the staff team.

The design and layout of the centre were generally suitable to meet the assessed needs of the residents living there. However, the fabric of the building was found to be in a poor state of repair. This is discussed in more detail under Regulation 17: Premises; however, extensive upgrades were required to ceilings, walls, flooring, including fixtures and fittings both in communal areas and in resident bedrooms.

During the walk around the centre, inspectors identified several fire safety concerns. These included fire doors in the dining room being propped open with a chair and doors that did not close properly when self-closure mechanism was released. These issues could compromise effective fire containment within the centre.

There was a slow response by the provider in identifying and addressing maintenance issues in this centre, which had the potential to impact on the quality of life for residents. For example, access to an internal garden area was blocked due to the growth of weeds at the door entrance. While inspectors acknowledged that the provider was in the process of developing plans for the redevelopment of the centre there had been no material change to the fabric of the centre since its registration in February 2026.

While the centre was observed to be clean, several areas of concern regarding infection prevention and control (IPC) were identified. For example, the housekeeping room was not laid out to support effective IPC practices, this, and other infection control matters are discussed further in the report under Regulation 27: Infection control.

Observations on the day confirmed that staff actively encouraged residents to engage in the organised activities. The activities available for residents on the day of the inspection consisted of chair exercises, yoga, dancing, bowling, and music. The activity programme was available for residents to participate in seven days a week.

Overall, residents were complimentary about the quality of the food provided, and were happy with the menu. The meal options available on the day consisted of a salmon or a steak meal. Inspectors noted that the dining room appeared uninviting, tables were not set, and there were no condiments on the tables. Information on the daily menu was written on a notice board but did not give any information about any accompanying vegetables or sauces.

The next two sections of the report, capacity and capability and quality and safety, will describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This unannounced inspection was carried out to monitor compliance with the Health Act 2007 Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 as amended. Genesis Healthcare Castlereagh Limited is the registered provider of this designated centre, which was first registered by the Chief Inspector of Social Services in February 2026. It is a company comprised of a board of three directors, who are involved in the operation of other designated centres for older persons. The registered provider was represented by one director in engagement with the Chief Inspector.

This centre was registered with a number of identified risks relating to the premises, infection prevention and control, and fire safety. As part of the registration application, the provider committed to addressing these risks. Consequently, the centre was registered subject to two additional restrictive conditions. Condition 4 required the completion of premises-related works, while Condition 5 required the completion of specified fire safety works. Both conditions prohibited the admission, or transfer of residents to the centre until the required works had been completed.

The findings of this inspection confirmed that there had been no substantial progress in addressing the core elements of the restrictive conditions mentioned above. While inspectors acknowledge there was ongoing engagement with the office of the Chief Inspector of Social Services regarding redevelopment plans for the centre, these plans were at an early stage of development, and currently did not meet the requirements of the regulations. This meant that the existing 26 residents were living in a centre that required extensive upgrade and refurbishment.

On the day of the inspection, inspectors found that management systems and current oversight arrangements were not sufficient in order to provide a service that is safe, appropriate, consistent and effectively monitored. An immediate action was issued during the inspection regarding access and safe storage of sharps as described under Regulation 27: Infection control.

Access to records to assist the inspection process was limited, and meant that the provider was unable to demonstrate compliance with some regulations. The directory of residents was unavailable at the time of inspection; however, inspectors acknowledge that the provider submitted several records post inspection. Access to quality information, and effective information systems are central to ensuring that residents care and welfare are maintained.

Systems to monitor the quality of the service, including the effective supervision of staff, were weak. The current monitoring systems failed to identify several risks in relation to current infection prevention and control (IPC) practices. In addition, oversight systems in place to ensure care plans reflected residents' needs were not

fully effective in the centre. Care plan audits did not capture the findings of the inspection as discussed under Regulation 5: Individual assessment and care plan.

Records of one provider meeting and one household meeting were made available post inspection.

A review of staffing rosters found that staffing levels were adequate to meet the needs of the 26 residents, and were appropriate to the size and layout of the centre. Direct care was provided by a team of registered nurses and healthcare assistants. Sufficient housekeeping, activities, and catering resources were in place, with maintenance support available three days per week.

There was a comprehensive training programme in place which incorporated a selection of both face-to-face and online training. Records confirmed that all staff were up to date with their mandatory training in safeguarding, fire safety, and manual handling. Supplementary training available for staff included training on medicine management, falls prevention, and dementia focused training.

The provider maintained a complaints policy and procedure to process and manage complaints received. This procedure was advertised in the designated centre near the main office.

Regulation 15: Staffing

There were sufficient staff on duty on the day of the inspection to meet the assessed needs of the residents. A review of worked and planned rosters confirmed that there were always two nurses on duty in the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training records were not available on the day of the inspection, however the provider submitted the training matrix post inspection. A review of the records submitted found that all staff had access to mandatory training with regard to the safeguarding of vulnerable people, fire safety, and moving and handling practices. Staff had also completed training relevant to infection prevention and control, in addition the person in charge had identified two members of the clinical team as IPC link practitioners but as yet they had not completed the national IPC training course.

Judgment: Compliant

Regulation 19: Directory of residents

The provider did not make available a directory of residents on the day of the inspection in accordance with Schedule 3 of the regulations.

Judgment: Not compliant

Regulation 21: Records

There was limited availability of several records on the day of the inspection and several records were submitted post inspection by the provider; however, they were found to be in breach of Schedules 1 and 3 of the regulations, as the following records were not accessible. For example:

- The directory of residents was not available for review on the day of the inspection.
- Only one contract for the provision of services was available on the day.
- The training Matrix was unavailable for review.
- Not all staff team meeting records were available at the time of the inspection.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider maintained a contract of insurance against injury to residents. This contract was due for renewal in February 2027.

Judgment: Compliant

Regulation 23: Governance and management

There was a leadership and management team in place with clear lines of authority and accountability. The management structure was in line with the structure set out in the centre's statement of purpose. However, there were weaknesses found in this structure on the day of the inspection, for example:

- The provider was unable to provide access to a number of records to support the inspection process on the day of the inspection. The arrangements in

place to ensure key information is known, and accessible to the local and senior management team required strengthening. This had the potential to impact on the ability of the provider to make informed decisions about the service as key information may not be readily available to support this process.

While inspectors found that there were sufficient staffing resources available to provide the service, the provider had not made available sufficient resources to adequately address known risks associated with Regulation 28: Fire precautions, Regulation 17: Premises and Regulation 27: Infection control as identified in Conditions 4 and 5 of the centre's registration.

The management systems in place did not ensure that the service provided was safe and effectively monitored. This was evidenced by:

- Delays in addressing all known fire safety risks continue to pose serious fire safety risk in the centre.
- The management systems in place did not provide adequate assurance that infection prevention and control (IPC) practices were effectively managed to protect residents and staff from the risk of infection, and were not fully aligned with recognised best-practice standards. An immediate action was issued on the day of the inspection regarding the oversight and management of sharps within the centre. This matter is discussed further under Regulation 27: Infection Control.
- The audit and quality assurance processes in place were not effective in identifying areas requiring improvement. For example, a number of infection prevention and control (IPC) issues identified during the inspection had not been identified through the provider's own auditing systems. This indicated that the existing audit process was not sufficiently robust to provide effective oversight of IPC practices within the centre.
- The provider had not ensured that infection prevention and control (IPC) policies were reviewed and updated in line with current evidence-based guidance. The absence of up-to-date IPC policies meant that staff may not have been supported by current best-practice guidance, representing a gap in the governance and oversight of IPC arrangements within the centre.
- Care plan audits had not identified deficits in two residents' care plans, which meant that their assessed care needs may not be met.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

There was one contract for the provision of services made available for the inspectors to review. Part C of the contract relating to the fees for individual services required updating in respect of the provision of physiotherapy supplied by the

registered provider. An updated copy of the contract was submitted to the inspectors post inspection.
Judgment: Substantially compliant
Regulation 3: Statement of purpose
The statement of purpose dated 27/01/2026 required an amendment to accurately describe the following • The number of staff available to provide the service. • An accurate description of the services available for residents to use. • The number of bed spaces available for occupation. • An updated version of the Statement of Purpose was received by inspectors the day after the inspection.
Judgment: Substantially compliant
Regulation 34: Complaints procedure
There was an accessible complaints policy, and procedure in place to facilitate residents and or their family members lodge a formal complaint should they wish to do so. The policy required minor amendments to the timescales This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion. A review of the complaint's log indicated that the provider had managed two complaints in line with the centre's complaints policy.
Judgment: Compliant
Quality and safety
Residents were mostly content with the level of service received from the provider to address their health, and social care needs. Overall, care, and support was delivered to a good standard to achieve positive outcomes for the residents. While the inspectors observed kind and compassionate staff treating residents with dignity, and respect, findings also confirmed that significant action was required to improve

the quality, and safety of service provision. In particular, targeted focus was required to address the deficits identified, and discussed under Regulation 17: Premises, Regulation 28: Fire Precautions, and Regulation 27: Infection control.

Residents had access to appropriate health, and medical care services. There was a general practitioner (GP) available to residents. Furthermore, residents were supported by a team of health, and social care professionals, including a dietitian, physiotherapist, optician, and occupational therapist. A community palliative care, and a psychiatry of later life team also formed part of the multi-disciplinary support for residents. The recommendations made by the allied health care professionals were incorporated into the residents' care plans.

A sample of residents' care records was reviewed, and discussed with the clinical staff on duty. A small number of care plans required additional information in order to identify effective interventions to meet the resident's assessed needs.

The premises were not well-maintained to ensure the needs, and rights of residents were fully in line with the requirements of the regulations. Many areas of the centre were found to be in a poor state of repair, and the current systems in place did not ensure that issues were identified, and addressed in a timely manner.

Fire safety concerns identified during the registration process had not been fully addressed by the provider. However, records confirmed that regular fire safety monitoring was being carried out in the centre. Monthly simulated evacuations were conducted, and residents' personal emergency evacuation plans (PEEPs) were reviewed, and updated regularly. Documentation also confirmed that fire alarm system, emergency lighting, and fire extinguishers were inspected, and serviced by qualified fire engineers.

Staff members present on the day of inspection demonstrated a good understanding of local fire procedures, and the evacuation arrangements for residents in the event of a fire emergency. Since the centre's registration in February 2026, the provider had also secured the gas compound, and provided an appropriate smoking shelter for residents who smoke. Additionally, two garden sheds that did not provide adequate fire protection were being emptied in preparation for decommissioning. Despite these positive actions, significant fire safety risks remained, and required further action by the provider, these are discussed in more detail under Regulation 27: Fire precautions.

Inspectors found that the provider did not comply with Regulation 27: Infection control, and the *National Standards for Infection prevention and control in community services* (2018). Weaknesses were identified in IPC, environment, and equipment management. Details of the relevant issues identified on inspection are set out under Regulation 27: Infection control, and Regulations 23: Governance and management.

There was an activity programme in place which was advertised in the centre, and available for residents seven days a week. Residents were observed to be engaged

with the activities provided on the day, and were observed to be in receipt of appropriate staff support.

Overall, inspectors found that residents were happy with the quality, and quantity of food provided. However, inspectors found the layout of the dining room was uninviting. Tables were not set for residents use, and there was a lack of visual representation of meal provision available on the day.

Regulation 17: Premises

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Upgrade and repair were required in relation to ceilings, walls and flooring. throughout the designated centre to include all communal rooms and resident bedrooms.
- Fixtures and fittings required replacement or repair with regard to communal and resident rooms.
- The external facilities require upgrade to satisfy the requirements of Schedule 6, in terms of the provision of external grounds that are suitable and well maintained.
- A number of resident's rooms were overlooked, and this had the potential to compromise residents' access to privacy and dignity.
- There were inadequate storage facilities both internally and externally.
- The bain-marie in the kitchen required repair.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider did not ensure that IPC procedures, consistent with the standards published by the Authority were in place and were implemented by staff. Hand hygiene facilities, and staff practices were not consistently in line with national guidelines, and best practice standards. For example:

- Alcohol-based hand rub, and liquid soap cartridges, which were intended for single use, had been opened, and topped up from larger containers. This practice increases the risk of contamination of the product, and may compromise effective hand hygiene.
- Two clinical hand hygiene sinks were not equipped with wall-mounted soap dispensers, which may impact staff access to appropriate hand hygiene products at the point of care.

- One dispenser was incorrectly labelled as containing alcohol-based hand rub when it contained liquid soap. This created a risk that staff may not be able to readily identify the correct hand hygiene product for use

The management of sharps was not in line with best practice guidance. For example,

- A number of sharps containers were overfilled, and had not been signed or dated appropriately. In addition, some sharps containers were stored in a location accessible to residents, presenting a risk of injury. An immediate action was issued on the day of inspection requiring the removal of these sharps containers, and the implementation of safe storage arrangements.
- The needles in use did not incorporate safety-engineered devices to reduce the risk of needlestick injury.

Linen was not managed in line with the National Standards, and national infection prevention and control guidance for the safe handling of linen. For example,

- Staff informed inspectors that soiled linen was pre-soaked prior to laundering rather than being placed directly into a water-soluble (alginate/red soluble) bag, and transferred to the washing machine. This practice increased the risk of environmental contamination, and unnecessary handling of soiled linen, thereby increasing the potential risk of cross-infection.
- Staff were observed carrying soiled linen in their arms along corridors from residents' bedrooms rather than using a designated linen skip at the point of care. This practice increased the risk of contamination of staff uniforms.
- Laundry facilities required review to ensure they were suitable for the volume, and type of linen being processed. For example, domestic washing machines were in use for laundering all residents' clothing, and linen. The provider had not demonstrated that the laundry equipment available was sufficient to support effective infection prevention, and control practices, and meet the laundering needs of the centre.

Housekeeping practices were not consistently in line with best practice guidance for the safe storage, and preparation of cleaning chemicals. For example:

- The chemical dosing system used for the dilution, and preparation of cleaning products was located within the dirty utility room. The location of the dosing system in an area designated for the handling of contaminated equipment, and waste increased the risk of contamination.
- There was no hand wash sink available in the housekeeping room.

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of the inspection, the registered provider had not taken all adequate precautions to ensure that residents were protected from the risk of fire. For example:

- Verification was required to ensure the shutter between the dining room and kitchen is fire-rated and automatically linked to the alarm system.
- Several fire doors did not have effective intumescent strips and smoke seals in place to stop the spread of smoke or combustible fumes.
- Fire doors leading from the dining room to the corridor were held open by chairs.
- A large, significant opening was found in the fire-rated ceiling of the electrical/boiler room, requiring immediate repair.
- Self-closing devices on a number of fire doors required adjustment to ensure the effective closing of fire doors.
- The provider had not replaced or repaired all fire door sets throughout the centre, and had not fitted fire-rated doors to all high-risk rooms that currently do not have such a door.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents' care plans were reviewed and overall, were updated in a timely manner. However, inspectors observed that two residents did not have an appropriate care plan in place to guide their care. For example,

- One resident's risk assessment indicated that they were a high risk of absconscion; however, there was no corresponding care plan in place to indicate how this risk was managed, or the required intervention needed to maintain their safety.
- The care plan interventions for one resident who presented with a communication need required more detail to adequately guide staff on how to support this resident. The current interventions were limited, mostly generic, and did not adequately account for their individual needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate medical and social and health care support to meet their needs. Residents had timely access to their general practitioners (GPs), and specialist services such as tissue viability, and physiotherapy as required.

Residents also had access to other health, and social care professionals such as speech and language therapy, a dietitian, and chiropody.

Judgment: Compliant

Regulation 8: Protection

The provider was acting as a pension agent for five residents living in the designated centre. A review of records made available confirmed the following,

- The person in charge is the signatory of the pension agent forms
- A separate resident account was set up in order to receive residents' social welfare payments separate from that of the registered provider.
- There were records in place to monitor, and reconcile residents financial records.
- Financial statements were available for residents or residents nominated individuals.

Judgment: Compliant

Regulation 9: Residents' rights

The premises did not consistently provide a homely environment for residents. For example, one resident's bedroom was not equipped with a television, which may impact residents' comfort and their ability to access recreational activities in private. The quality of the facilities made available for resident use was substandard, as described under Regulation 17: Premises.

Additionally, some bedrooms that had been reconfigured from twin to single occupancy retained redundant furnishings and fittings, detracting from the overall presentation of these rooms.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Fearna Manor Nursing Home OSV-0000339

Inspection ID: MON-0049700

Date of inspection: 19/06/2026

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 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: A current directory of residents, containing all information required by Schedule 3, will be maintained in both electronic and controlled hard-copy format in the designated centre. The Person in Charge (PIC), Clinical Nurse Manager (CNM), Nursing Staff and administrator will have access to the directory, including when the PIC is absent.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A Schedule 2, 3 and 4 records register will be completed by the PIC to identify each required record, its owner, storage location, retention period and authorised access arrangements. The directory of residents, contracts of care, staff training matrix, staff meeting records and other inspection records will be held in an indexed inspection file, with electronic copies stored in a secure shared location accessible to the PIC, CNM and authorised senior management. The PIC will complete a monthly records-availability check and record any deficit on the centre's quality improvement plan. The Head of Operations will undertake a quarterly sample audit to verify that required records are complete, secure, current and immediately retrievable. Any missing record will be escalated and corrected within five working days.	

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 has strengthened local and senior oversight through clearly documented governance arrangements. A Governance, Risk and Compliance Lead has been added to the senior management team to provide further oversight and support in relation to records, fire safety, premises, infection prevention and control (IPC), care planning and regulatory compliance. The PIC chairs a weekly governance meeting, which is attended by the Head of Operations. The Governance, Risk and Compliance Lead also attends these meetings regularly and reviews all meeting minutes. Governance meetings are supported by a standing agenda, risk register and action log. A KPI dashboard is currently under development and, once implemented, will provide additional oversight of key areas of service delivery and regulatory compliance. Overdue or high-risk actions are escalated to the Head of Operations and the registered provider representative. A refurbishment programme for the premises, fire-safety and IPC works required under Conditions 4 and 5 has been planned, approved and resourced, and will be monitored at weekly works-governance meetings until completion. Progress will be evidenced through contractor reports, photographs, invoices, certificates and independent professional sign-off. These works are due to commence in early September with an expected completion date of January 2027. Restrictions on admissions and transfers will remain in place until the relevant conditions have been discharged by the Chief Inspector. The audit programme will be revised to include monthly IPC, care-plan, records, premises and fire-safety audits. Each audit will include observation of practice, a defined sample, corrective actions, responsible persons and due dates. The Clinical Governance, Risk and Compliance Lead will validate closure of actions and report trends and assurance to the registered provider each month. IPC policies will be reviewed by the Head of Operations and Clinical Governance, Risk and Compliance Lead against current national guidance and issued through a controlled policy register, with staff briefing and competency checks.	
Regulation 24: Contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services: The contract for the provision of services has been reviewed and amended so that Part C clearly identifies the services included in the overall fee and any additional charge, including the arrangements and applicable charge for physiotherapy supplied by or through the registered provider.	

All current residents' contracts will be checked against the revised template. Where an amendment is required, the resident and/or representative will receive a written addendum for agreement and signature, issued by the administrator. The administrator will maintain a contract tracker, and the PIC will verify completion through a monthly audit until 100% of current contracts are compliant; thereafter, every new contract will be checked before admission.

Regulation 3: Statement of purpose

Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

An updated Statement of Purpose was submitted to the Regulator on June 22nd 2026.

Regulation 17: Premises

Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider will implement a phased premises refurbishment programme covering all communal areas and resident bedrooms, which remains under consultant with the regulator. The schedule will include repair or replacement of walls, flooring, fixtures and fittings; provision of adequate internal and external storage; and upgrading and maintenance of external grounds. Resident access to safe outdoor space will be maintained throughout the works, subject to risk assessment.

The Bain Marie was replaced on July 6th 2026 and the damaged ceiling in the electrical/boiler room has been repaired.

Bedroom privacy will be reviewed individually. Privacy film, screening or other suitable measures will be installed where rooms are overlooked, following consultation with residents. Rooms previously reconfigured from twin to single occupancy will have redundant fittings removed and will be redecorated and furnished in a homely manner. Works will be phased to minimise disruption, with resident and family communication, infection-control measures, fire-safety controls and daily environmental checks documented throughout.

The maintenance lead will complete a weekly premises inspection; defects will be risk-rated, assigned and tracked to closure. The PIC and Head of Operations will review progress weekly, and completion will be confirmed through a room-by-room Schedule 6 audit and photographic evidence.

Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: The immediate sharps risk has been controlled by removing overfilled and unsecured containers, placing all sharps bins in secure locations at the point of use, and introducing a check that every container is assembled, labelled, dated, closed over when not in use and closed completely once it reaches the fill line. Safety-engineered needles have replaced conventional needles. The nurse in charge will check sharps management on every shift and the PIC/CNM will audit compliance weekly for eight weeks and monthly thereafter. Single-use soap and alcohol-based hand-rub cartridges are no longer opened or topped up. All dispensers will be correctly labelled, and wall-mounted soap dispensers have been installed at the two clinical hand-wash sinks. Hand-hygiene facilities and practice will be observed weekly until sustained compliance is demonstrated. Soiled linen is now bagged at the point of care in the appropriate water-soluble and outer bag and transported in a designated, covered linen skip. Pre-soaking and carrying loose linen have ceased. Staff have received practical instruction and observed competency assessment on linen handling. The laundry equipment in use at the time of the inspection have been removed and replaced by commercial equipment. The chemical dosing system has been relocated from the dirty utility room to a clean, secure housekeeping area. A dedicated clinical hand-wash sink will be installed in the housekeeping room during the renovation works. IPC policies will be updated to current national guidance, and the IPC link practitioners will complete the national IPC link-practitioner programme. Monthly IPC audits will include observation of practice, hand hygiene, sharps, linen, laundry, housekeeping and environmental/equipment management, with actions tracked through clinical governance.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire doors will not be wedged or held open unless fitted with an approved hold-open device linked to the fire alarm. Staff have been de-briefed regarding this and the nurse in charge will check escape routes and fire doors on every shift. The kitchen/dining-room shutter was repaired on August 18th 2026 and is now connected to the fire alarm system, whereby the shutter closes automatically when the fire alarm is activated.	

A competent fire consultant will complete and certify a survey of compartmentation, fire doors and high-risk rooms. The survey and remedial programme will replace or repair defective fire-door sets; fit effective intumescent strips and smoke seals; adjust self-closing devices; provide suitable fire-rated doors to all high-risk rooms; and address any further defects identified. Completion certificates and an updated fire-safety risk assessment will be retained in the centre.

The PIC will maintain a fire-safety register covering daily means-of-escape checks, weekly alarm tests, monthly fire-door/compartment checks, servicing and drills. Fire procedures will be displayed prominently at suitable locations and reviewed after works. Simulated evacuation drills will continue across different staffing levels and compartments, with learning actions recorded and personal emergency evacuation plans updated where necessary

Regulation 5: Individual assessment and care plan

Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

The resident assessed as being at high risk of absconsion now has a person-centred care plan that clearly describes triggers, preventive measures, supervision, safe response, escalation and review arrangements drafted by the CNM. The resident with communication needs has an individualised communication care plan describing preferred methods, abilities, supports, time required, non-verbal cues and effective staff approaches. Residents and/or their representatives have been consulted and the outcome documented.

The PIC/CNM will review all residents' assessments and associated care plans to confirm that every identified risk or need has a corresponding, current and individualised plan. A revised monthly care-plan audit tests alignment between assessment, plan and practice and includes direct staff discussion. Deficits will be corrected within two working days and trends reported at clinical governance meetings.

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Each resident's bedroom will be reviewed with the resident and/or representative to ensure it is homely, personalised and supports privacy, comfort, occupation and recreation. A suitable television has been provided to the resident identified by inspectors and others, subject to the residents' wishes. Redundant fixtures and furnishings in bedrooms converted from twin to single occupancy will be removed and the rooms made good. Comfortable, domestic-style seating has been provided in reception and communal areas following consultation with residents. Daily newspapers and other preferred media have been made routinely available, and residents will be supported to access radio, television and internet services. The activities coordinator will record individual preferences and monitor access through resident meetings and quarterly satisfaction checks. The PIC will complete a monthly residents' rights and environment walk-around with resident representation, with findings and actions reported through the centre's governance meeting.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/01/2027
Regulation 19(2)	The directory established under paragraph (1) shall be available, when requested, to the Chief Inspector.	Not Compliant	Orange	22/06/2026
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	Orange	31/08/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Not Compliant	Orange	31/08/2026

	be safe and accessible.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	22/06/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/08/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/08/2026
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	Substantially Compliant	Yellow	31/08/2026

	the fees, if any, to be charged for such services.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Orange	31/10/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/10/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/10/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/10/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	31/10/2026

	reviewing fire precautions.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	18/08/2026
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	18/08/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	22/06/2026
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).	Substantially Compliant	Yellow	26/06/2026
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident is facilitated to communicate freely and in	Substantially Compliant	Yellow	14/08/2026

	particular have access to radio, television, newspapers, internet and other media.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	14/08/2026