



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Rosemount House Nursing Home
Name of provider:	Rosemount Nursing Home Limited
Address of centre:	Garrabeg Road, Church Street, Gort, Galway
Type of inspection:	Unannounced
Date of inspection:	18 February 2026
Centre ID:	OSV-0004583
Fieldwork ID:	MON-0049516

About the designated centre

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

Rosemount House provides 24 hour nursing home care for adults ranging in age from 18 to 65 and older, both male and female, in a comfortable, relaxed and homely environment. Residents who require convalescent, respite, short and long term care with low, medium, high and maximum dependencies can be accommodated. The facilities include the single storey purpose-built nursing home and secure garden/courtyards.

The centre provides accommodation for 40 residents in single and twin bedrooms, a number of which are ensuite.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	35
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 18 February 2026	09:30hrs to 17:30hrs	Catherine Sweeney	Lead
Tuesday 10 March 2026	09:30hrs to 15:30hrs	Catherine Sweeney	Lead
Wednesday 18 February 2026	09:30hrs to 17:30hrs	Sharon Kane	Support
Tuesday 10 March 2026	09:30hrs to 15:30hrs	Sharon Kane	Support

What residents told us and what inspectors observed

The feedback from residents and visitors in relation to the care received was generally positive, however, inspectors found multiple non-compliances, across the regulations reviewed, which posed a risk to the quality of care and safety of residents in the centre.

Significant areas of non-compliance were identified in relation to the premises, fire precautions, infection prevention and control, risk management, and overall governance and management. In addition, the condition and maintenance of the care environment did not consistently ensure residents' safety, dignity, or well being.

This unannounced inspection was scheduled for one day. However, due to the level of non-compliance identified and the requirement to issue an urgent compliance plan, a second day of inspection was scheduled. On day one of the inspection, there were 35 residents accommodated in the centre, with five vacancies. On arrival, inspectors met with a general manager and a newly appointed director of nursing. There was no person in charge in the centre, appropriately notified to the Chief Inspector, at the time of the inspection. Following an introductory meeting, inspectors conducted a walk through the premises.

The designated centre is a single-storey, purpose-built facility located in Gort, County Galway. It was registered to accommodate up to 40 residents and comprised single and twin bedrooms, along with communal areas including a day room, dining room, and sun room.

In general, staff and resident interactions were observed to be kind and friendly, however, inspectors observed that care was not always delivered to a high standard. Inspectors observed poor, unsafe manual handling techniques being used when transferring a resident. Furthermore, residents told inspectors that there were times when they had to wait extended periods of time to be attended to. This included residents with poor skin integrity having to wait a significant amount of time to be moved from seating with no pressure support, to appropriate seating.

Some residents were observed spending time in one of the communal days rooms, while others stayed in their bedrooms. An activity schedule was in place, and designated staff were assigned to facilitate activities. Residents reported that there were activities available, and stated that they could choose how to spend their day. However, one resident described that the activities on offer were not of interest to them. The day room was supervised by staff throughout the day, however, the arrangements in place to supervise residents who chose to stay in their bedrooms was not robust, particularly in relation to meal-times. Inspectors observed that staff did not recognise when residents had not eaten their meals, or residents who could

not access their drinks because of their position in bed. This was found to impact on the management of residents at risk of malnutrition and dehydration in the centre.

Inspectors observed lunch-time meal services on both days of the inspection. The dining room in the centre did not have capacity for all residents to attend, if they wished. While there was communal space available to extend the dining options, this was not considered, and therefore, multiple residents were served their meals on trays in their bedrooms or in the communal day rooms. The option of two sittings for meal times had not been considered. This current arrangement impacted on the ability to supervise residents who were assessed as having risks associated with eating. It was also noted that both residents in the dining room, and residents in their bedrooms were served their main meal and dessert at the same time. This was observed to be distracting for residents with cognitive difficulties.

A review of the menus on the table found that the daily menu did not reflect the meals served to residents. For example, on day one of the inspection, the menu stated that one option was pan-fried chicken. However, residents were served chicken curry, rice, vegetables and mashed potato. Three residents did not eat their meals. This was not identified or recorded by staff. On day two of this inspection, the menu described an option of lamb stew which was also not available.

Inspectors identified a number of concerns in relation to the maintenance and upkeep of the premises. Flooring throughout the centre was damaged and unsightly. Inspectors observed that the floor surface was sticky, with furniture and footwear catching on the floor, posing a potential falls risk to residents while mobilising. Wall coverings in several bedrooms were damaged. The condition of these surfaces meant that they were not amenable to effective cleaning. Staining and damage were also noted on ceilings in some bathroom areas. A designated smoking room was located off the day room; however, it was not adequately ventilated. A strong smell of smoke was evident in the day room and surrounding corridors. This was not conducive to a safe and comfortable atmosphere for residents who chose to spend time and eat their meals in the day room.

Communal rooms were being used to store household supplies such as toilet rolls and hand towels. The centre was observed to be cluttered throughout, contributing to an untidy environment. Store rooms in use were not organised effectively, which made accessing products and equipment difficult.

Equipment for resident use was not consistently maintained in a clean condition. For example, chairs in the communal areas were visibly worn and soiled, and bedpans were stained despite being identified as clean and ready for use. The cleaners' store room did not have a dedicated hand-washing sink.

The outdoor area available to residents was not adequately maintained. Moss was present on pathways, creating a potential trip hazard. The roof of the centre was also covered in moss.

Call bells were not available in all rooms in use by residents, including shared bathrooms and the day room, presenting a risk should residents require immediate assistance.

Bedroom accommodation comprised of single and twin bedrooms, a number of which had en-suite facilities. While shared bedrooms were of sufficient size, inspectors found that the design and layout did not fully meet the current care needs of residents. Privacy screening was not available in all shared bedrooms, meaning residents did not consistently have access to adequate private space. There was a sufficient number of toilets and bathroom facilities available; however, one shower in a shared bathroom was out of order on the day of inspection.

Capacity and capability

This unannounced inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). Inspectors also reviewed notifications that had been submitted to the Chief Inspector by the provider. Inspectors also followed up on unsolicited information received by the Chief Inspector in relation to staffing. This information was found to be substantiated on this inspection.

Overall, the findings of this inspection were that the management systems in place to monitor and oversee the service did not ensure that care was delivered to a high standard, and that the residents were safe. In addition, the registered provider had not fully implemented a compliance plan, submitted following a previous inspection of the centre in September 2025, in relation to premises, fire precautions, records, governance and management, and residents' rights. This inspection found that there was continued non-compliance in relation to Regulation 23: Governance and management, Regulation 18: Food and nutrition, Regulation 17: Premises, and Regulation 28: Fire Precautions.

The provider was required to submit an urgent compliance plan to the Chief Inspector following day one of this inspection, to give assurance that the risks regarding water supply to the centre were addressed, that the nutritional needs of residents at risk of malnutrition were addressed, and that there were appropriate deputising arrangements in place in the event of absence of the director of nursing. Following day two of the inspection, the provider was required to submit a further urgent compliance plan in relation to fire precautions in the centre.

Rosemount Nursing Home Limited is the registered provider of the centre. The registered provider is a company that comprises of four directors. The registered provider is represented by one director in communications with the Chief Inspector. Two other directors attended the centre on day two of this inspection. Inspectors were informed that there was ongoing communication between the management in

the centre and the directors of the company in relation to resources, management of risk, and the general oversight of the service. However, these communication systems were found to be ineffective. There was no documented meetings between the provider and the management team, outlining any discussion in relation to the service. There was no action plan or time lines in relation to required work to the centre.

On the first day of the inspection, there was no person in charge of the centre, as required by the regulations. The Chief Inspector had been notified of a proposed candidate, however, the notification could not be progressed due to the failure of the provider to submit supporting documentation. By day two of the inspection, the required documentation was received by the Chief Inspector, and there was a person in charge in place. However, there was no deputising arrangements in place for key management roles, including the person in charge, in the event of an unplanned absence.

The management structure within the centre consisted of a general manager and a newly appointed director of nursing. the provider was in the process of recruiting a clinical nurse manager, however, this role was vacant at the time of this inspection. This inspection found that the current management structure was disjointed, with no clear lines of responsibility and accountability. As described above, there was no formal communication structures between the registered provider and the management team in the centre, and no clear escalation pathway to report issues of concern or risk. This uncertainty impacted on the oversight and the safety of the care provided to the residents in the centre.

The team providing direct care to the residents consisted of registered nurses and a team of health care assistants. There was inadequate levels of staff available to ensure that residents' needs were attended in a timely manner. In addition, due to the finding relating to fire safety risks in the centre, the level of staffing rostered on the night shift was not adequate to ensure that all residents could be safely evacuated in the event of a fire emergency.

Staff had access to education and training appropriate to their role. The provider had made arrangements to facilitate mandatory staff training such as manual handling, safeguarding, fire precautions and infection prevention and control. However, staff did not demonstrate appropriate awareness of either manual handling training, or the fire management systems in the centre. The provider had failed to assess and monitor the effectiveness of the training provided to staff. In addition, staff were not appropriately supervised. Staff were observed to be poorly allocated, particularly at meal times. Inadequate levels of supervisory staff resulted in a poor standard of general care delivery, observed throughout this inspection.

Records were poorly maintained in the centre, and were not easily accessible. Multiple files containing resident information were stored on the floor of the nurses' office, or in boxes in store rooms. Record management systems consisted of both an electronic and a paper-based system. Furthermore, a sample of staff personnel files

were reviewed and did not contain all the information required by Schedule 2 of the regulations. This was a repeated non-compliance from the last inspection.

There was a risk management policy in place, however, it had not been updated to reflect the changes made to the regulation in March 2025. The centre had a risk register in place, however, known risks such as water supply, premises issues, and fire safety had not been identified and managed to ensure resident safety.

There was a complaints policy in the centre which was in line with the regulations. Complaints were acknowledged and managed in line with the requirements of the regulations.

Regulation 15: Staffing

The staffing level in the centre was inadequate to meet the needs of residents. This was evidenced by residents waiting extended periods of time to have their care needs attended to. In addition, the levels of staffing at night-time were not adequate in light of the high level of fire safety issues identified on this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

The registered provider had failed to ensure that the training provided to staff was effective. This was evidenced by staff demonstrating poor knowledge in relation to manual handling, and fire safety. There was also no record of training in the management of complaints. The provider had committed to completing this training following a previous inspection.

Staff were not appropriately supervised. There were inadequate levels of supervisory in the centre. This resulted in poor care practices such as,

- inappropriate manual handling techniques
- poor oversight of residents at risk of malnutrition
- poor oversight of residents at high risk of skin damage
- poor fire safety management. Fire doors were observed to be propped open, posing a risk to the functionality of the doors.

Judgment: Not compliant

Regulation 21: Records

Records were poorly managed and not stored in a manner that kept them safe and accessible.

Records were not consistently maintained as required by Schedule 2 of the regulations. For example, some staff personnel files did not contain evidence of staff members' qualifications, and did not include the required number of written references from previous employers, or a full employment history.

There were no records of tests of the fire equipment and of any actions taken to remedy any defects found in fire equipment.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The condition of the premises was extremely poor. Issues identified with the premises on multiple inspections, for which the provider had committed to addressing, had not been resolved. The provider had failed to ensure that adequate resources had been allocated to the maintenance of the premises. This posed a significant risk to the health and well-being of the residents.

In addition, the provider had failed to complete a fire safety survey, as committed to in a compliance plan submitted following a previous inspection of the centre.

The organisational structure within the centre was not clearly defined. The management team comprised of a general manager. A newly recruited director of nursing had commenced working in the centre. The provider had notified the Chief Inspector of the commencement of a new person in charge, however, they had failed to submit the required documentation for assessment, and therefore, there was no person in charge of the centre on the day of the inspection. It was unclear who held responsibility for the identification and management of risk in the centre. The escalation pathway of risk to the registered provider was also unclear. The appropriate authority and accountability of this management team was not clearly evidenced, and this was found to have a significant impact on the oversight and safety of the service provided. In addition, the provider had failed to ensure that there was deputising arrangements in place in the event of the absence of the director of nursing. This posed a risk to residents, as there was no other senior nursing staff working in the centre.

The provider had failed to ensure that there were management systems in place to ensure that the service delivered was safe, appropriate, consistent and effectively monitored.

This was evidenced by;

- Inadequate risk management systems. Significant deficits in the water system had been identified in January 2026. There was no time-bound plan in place to address this risk.
- Inadequate clinical oversight of residents' nutritional risk. A significant number of residents had lost weight in the centre over the past three months. This risk was not identified by the nursing staff and therefore, no action was taken to address this risk.
- The maintenance of the premises was poor. Inspectors observed significant deterioration in multiple aspects of the centre including damaged and unclean flooring throughout the centre, poor ventilation of a smoking room causing a strong smell of smoke in the day room used by residents, moss covering the roof of the centre, and a poorly maintained out door area, that was not safe for resident use.
- Inadequate systems of communication with respect to risks, with no evidence of issues of risk being escalated to, or discussed with, the provider.

The provider was issued with urgent compliance plans following day one, in relation to the premises, nutritional risk to residents, and the deputising arrangements for senior staff, and day two of this inspection in relation to fire safety.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre had a complaints procedure in place that outlined the process for making a complaint and the personnel involved in the management of complaints.

Judgment: Compliant

Quality and safety

This inspection found that the care and safety of residents was significantly compromised by inadequate systems of governance, as described in the capacity and capability sections of this report. This was particularly evident in the overall condition of the premises, which was found to be poorly maintained and unclean. Twin bedroom accommodation was found to be poorly laid out, and lacked privacy screening, impacting on the privacy of residents. In addition, damaged flooring throughout the centre had not been repaired and posed a significant infection control and tripping hazard to residents. These findings were repeated findings from previous inspections. The registered provider had failed to take action to address

risks and non-compliance that directly impacted the residents' safety and quality of life. Furthermore, inspectors were informed of issues with the water supply to the centre, and that remedial works were required to ensure a safe and consistent supply of water. On day one of inspection, there was no defined time plan in place for completion of these works.

On day two of the inspection, inspectors were informed that a review of the centre's fire doors following day one of inspection, had indicated that urgent action was required. No action had been taken by the provider to address this issue, and no mitigation measures had been taken to ensure residents' safety.

Inspectors also identified significant concerns in relation to residents' nutrition and the overall mealtime experience. The dietary needs of residents, as assessed and care planned, were not consistently met. A significant number of residents had experienced weight loss over the preceding three months, and this had not been appropriately identified or addressed.

Fire safety arrangements failed to ensure appropriate management of the risk of fire in the centre. A number of deficiencies with cross-corridor fire doors were noted such as not being able to close fully when released. Fire drills were poorly documented and did not provide adequate assurance that residents could be safely evacuated to a place of safety at any time, including during night-time hours. Staff spoken with were not clear in the actions that should be taken in the event of the fire alarm going off, and poor fire safety practice was noted on inspection, such as wedging open fire doors, and hoists charging in front of fire exits. Following the identification of fire risks in an inspection in September 2025, the provider had committed to a thorough survey of the fire safety systems by November 2025. This survey had not been completed. At the time of this inspection, the management and staff were unaware of the compartmentation of the centre and there were no documents available to identify where the compartment boundaries in the centre were. This information was required to ensure the safe evacuation of residents in the event of a fire in the centre.

Resident care records were maintained on an electronic care record system. Inspectors examined a sample of residents' files. Following admission, each resident had an assessment of their needs completed, and these assessments were used to inform the development of care plans. Overall, care plans reviewed were person-centred and contained the information to guide staff to deliver appropriate care to residents. However, not all care plans were found to be implemented. Inspectors observed that staff did not follow a resident's care plan when transferring a resident from their wheelchair to a comfort chair. In addition, residents who were assessed as being at high risk of skin damage, did not receive the care they required to ensure their safety. A review of the management of food and nutrition found that assessment and management of residents at risk of malnutrition was inadequate. Residents had not been accurately assessed for their nutritional risk, and therefore no action plan was developed to address the associated risks. For example, poor supervision and monitoring of residents intake resulted in a failure to recognise that a significant number of residents in the centre were losing weight.

The provider had systems in place to ensure that the residents were protected from abuse. A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff spoken with demonstrated good awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. All staff were up-to-date with safeguarding training.

Residents described having the freedom to choose how to spend their day. There was an activity schedule in place and residents were happy with the choice on offer. However, inspectors noted that residents were sitting in the day room with large television on, showing children's programs. Residents told the inspectors that they had no interest in the programs being shown.

Residents' privacy was not always considered. The lack of privacy curtains, and the layout of the twin bedrooms did not ensure that residents could enjoy an appropriate level of privacy in their bedroom. This was a repeated finding on previous inspections, that provider had committed to addressing. However, minimal action had been taken at the time of the inspection.

Visitors were observed coming to and from the centre during the day. Visitors spoken with described unrestricted visiting access. Visitors were observed spending time with loved ones in communal areas and resident bedrooms.

Regulation 11: Visits

The registered provider had ensured that arrangements were in place for residents to receive visitors. Residents who spoke with the inspector confirmed that visiting was unrestricted.

Judgment: Compliant

Regulation 17: Premises

The premises was found to be in a poor state of repair, and not aligned with the requirements of Schedule 6 of the regulations. This was evidenced by:

- Lack of hot water and working showers in the centre. Inadequate action had been taken to address water issues following an assessment by a competent person.
- An out of date and poorly functioning nurse call bell system
- Damaged and worn flooring throughout the designated centre
- Lack of appropriate storage throughout the centre. The front day room was used to store unopened gel dispensers and paper towels. Resident supportive equipment, such as walking frames and unused specialised seating was

stored in the communal areas of the centre. Residents' records and clinical files were stored in a manner that was disorganised. Boxes of residents' records were stored in equipment store rooms. Multiple clinical files were observed on the floor on the nurses' offices.

- Poor ventilation in the smoking room caused a strong odour of smoke in the day room
- Inadequate dining space for residents
- Large amounts of moss on roofing tiles
- Staining on ceilings in assisted bathrooms
- Furniture in the communal rooms was outdated and in a poor state of repair

Judgment: Not compliant

Regulation 18: Food and nutrition

Inspectors found that the dietary needs of each resident, as prescribed and planned, was not met. A significant amount of residents had lost weight in the centre over the past three months. An urgent compliance plan request regarding the management of nutritional risk was issued to the provider following day one of this inspection.

The meal time experience was observed to be chaotic and disorganised. Two small dining rooms, with limited seating, were available for residents use at lunch time. More than half the residents in the centre were served their meals on trays in the day rooms, or their bedrooms. While the residents had an option of beef or chicken for lunch, the chicken dish was different to the meal on the menu. Furthermore, it was a catholic religious holiday on the day of inspection, when fish would be traditionally eaten at meal time. There was no fish option available on the menu for residents to choose from.

Inspectors observed that desserts were served at the same time as the main course, on both serving trays, and at the dining room tables.

Inspectors observed that a significant number of residents, did not eat, or ate only small amounts of their meal. This was not identified and documented by staff.

By day two of the inspection, in line with the urgent compliance plan, most residents had their nutritional assessment and care plans reviewed, and care plans had been updated to reflect the needs of residents who had lost weight and were at risk of malnutrition. Specific plans were in place to monitor ongoing weight loss, and referrals had been made to a dietitian. However, one resident who was observed as having a minimal nutritional intake, did not have an up-to-date nutritional assessment completed, and therefore did not have an appropriate care plan in place.

Judgment: Not compliant

Regulation 26: Risk management

A risk management policy in the centre had not been updated to reflect the changes in the regulation from March 2025. The policy failed to describe how hazards should be identified and assessed, and did not describe the measures and actions that should be put in place to control an identified risk. As a result, known risks in the centre were not documented or managed in line with regulatory guidelines. A risk register had not been updated to reflect significant risks in relation to the premises, the water systems and fire safety systems.

Judgment: Not compliant

Regulation 27: Infection control

The centre was visibly unclean on the day of the inspection. The cleaning trolley observed on inspection was disorganised, and not in line with best practice guidelines. The floors in the centre were badly damaged and not amenable to proper cleaning. Cleaning staff had not received training in good hygiene practice and cleaning techniques.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Issues relating to fire safety were identified on the previous inspection of the centre. Following that inspection, the provider committed to have a full fire safety survey completed by November 2025. No survey had been completed at the time of this inspection.

Inspectors found poor practice in the management of fire safety.

- The management team informed inspectors that weekly checks of the alarm system were completed, and that some issues were identified during these checks. However, these checks were not documented, and there was no action plan in place to address any issues identified during these tests.
- Fire doors were observed to be propped open with cardboard or items of furniture. Some fire doors and frames were visibly damaged. This could impair the effectiveness of the door to contain smoke and fire, in the event of an emergency.

- Fire drills were poorly documented and did not provide assurance that residents could be evacuated to a place of safety in the event of an emergency, at anytime, day and night.
- Staff spoken with did not demonstrate appropriate knowledge of the action to take on hearing the fire alarm, or the correct procedure to evacuate residents to a place of safety. In addition, staff did not know where compartment boundaries started and ended, and therefore, were unaware of where residents should be moved to, if evacuation was required.

An urgent compliance plan request was issued in relation to fire safety following day two of this inspection. This plan was partially accepted.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessment and care plans found that they were not in line with the requirements of the regulations. For example, the needs of residents were not comprehensively assessed. A resident had a nutritional care plan that was not developed following a comprehensive assessment of the resident, including their risk of malnutrition, and therefore, their care plan did not meet the needs of this resident.

Care plans were not always developed following assessment of a resident. For example, a resident assessed as having a high risk of developing pressure ulcers did not have a care plan developed to reflect that risk

Care plans were not consistently implemented. A resident had a care plan indicating that they were for transfer using a hoist, however, this was not observed in practice.

Residents' care plans were not updated to reflect the assessed needs of the residents. For example, some residents, who had been assessed as being at high risk of malnutrition, did not have their care plan updated to reflect the change in their needs.

Judgment: Not compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. A safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that some residents could carry out personal activities in private. For example, the privacy screening in shared bedrooms did not ensure adequate coverage of the residents' individual bed space. In addition, the layout of some of the twin bedrooms in the centre meant that residents were required to enter the bed space of the other resident to access their personal belongings.

Residents were not offered choice in relation to meals. Meal menus were inaccurate and failed to describe the meal available.

The provider did not ensure that residents were consulted about, and participated in the organisation of the designated centre, as resident meetings were not recorded.

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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Rosemount House Nursing Home OSV-0004583

Inspection ID: MON-0049516

Date of inspection: 10/03/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Since inspection we have added one additional 8am to 3pm health care assistant We have added an additional health care assistant to 8pm to 8am shift. We have increased the nursing shift to include two 8am to 9pm nurses]	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff have completed the following : Manual handling, safeguarding, responsive behaviours and complaints training completed. Promoted three members of senior health care assistants to team leader positions. These members of staff will receive induction into that role, supervision from the PIC/CNM to ensure effective oversight of staff practices in delivery of person-centered care. They are responsible for the induction of all new staff with P[C/CNM having oversight. To address the deficits identified in the staff fire safety knowledge the following measures have been put in place. Refresher fire training has been arranged for all staff with the emphasise on evacuation procedures, compartmentalization knowledge, the use of evacuation equipment,	

horizontal evacuation and the roles of relevant staff in the exvacuation procedures.

Since inspection fire drills have been occurring weekly across all shifts including night simulations to ensure that staff can demonstrate competency during evacuation. The PIC/CNM/GM will complete competency assessments following fire drills to verify staff knowledge and to identify any additional knowledge gaps in knowledge.

Fire safety knowledge and emergency response responsibilities are discussed at daily handovers and safety pauses.

The PIC/CNM will continue daily walkabouts, attend handovers and safety pauses to maintain oversight of residents safety and any risks identified will be escalated accordingly and control measures put in place.

Formal reflective practice are now taking place and when a gap in learning is identified actions are taken to support staff development and to monitor development These measures are intended to provide stronger governance and reassurance that the staff have the knowledge skills and competence to maintain residents safety.

Regulation 21: Records

Not Compliant

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

In response to the findings under Regulation 21: Records, the registered provider has commenced a full review and audit of all staff personnel files to ensure compliance with Schedule 2 requirements and regulatory standards.

An inclusive checklist has been developed and is being used to review each staff file to confirm the presence and accuracy of all required documentation, including:

- Proof of identity
- Garda vetting disclosures
- Full employment history with explanations for gaps in employment
- Verified references
- Evidence of qualifications and professional registration where applicable
- Contracts of employment
- Records of mandatory training completed
- Records relating to supervision and disciplinary processes where relevant

Any incomplete files noted while completing the review are followed up with the relevant staff member as a matter of urgency. Staff who do not have all required documentation in place are risk assessed and control measures implemented in line with the centre's recruitment and governance procedures until full compliance is achieved, GM/PIC/CNM/Admin will have oversight of same. monthly audits of staff files will now be completed by the administrator to ensure ongoing compliance with Schedule 2 requirements. Findings from these audits will be reviewed as part of the management meetings and corrective actions put in place where necessary. These measures are intended to ensure oversight arrangements are in place and provide assertion that all

staff records are accurately maintained, monitored continuously and fully compliant with regulatory requirements. The nurses are completing twice daily fire checks, once in the morning and once in the evening, to monitor progress of the fire review process and ensure any deficits identified are addressed, management team are responsible for the oversight of same.

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Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Registered Provider has reviewed the governance and oversight arrangements within the centre to ensure accurate accountability structures, effective risk management processes and operation oversight.

An organisation chart has been developed and all staff made aware of the same and reporting structure.

The persona participating in management retains overall accountability for governance and regulatory compliance with the service. The Person in Charge is responsibility for the day-to-day operation of the centre, clinical oversight, staff supervision, safeguarding the residents and risk management. In the absence of the Person in Charge the Clinical Nurse Manager deputises and has oversight of the above. Staff nurses and team leader are responsible for care safe care practices and escalating concerns to CNM/PIC/GM who will then inform the provider.

Risks identified within the centre are appropriately communicated, monitored and addressed accordingly.

Daily handovers, safety pauses and walkabouts are completed by the PIC/CNM to identify any environmental, operational or clinical risks and plans are put in place.

Weekly management meetings are conducted involving the GM, PIC, CNM and administrator to review both clinical and operations risks, incidents, complaints, staffing levels, fire safety, IPC, audit results and quality improvements plans are put in place.

Nutritional oversight will be monitored by the PIC/CNM. Weekly MUST score reports are provided to nursing staff to ensure that residents identified at risk are weighed and monitored and corrective actions are put in place. Monthly weights and MUST assessments are completed for all other residents. The PIC/CNM will review these reports to ensure interventions, appropriate referrals and care plans are updated to reflect change.

The GM/PIC/CNM will monitor the dining room experience with weekly dining room audits in place and quality improvements plans where required.

Staff are allocated morning handover to ensure that resident nutritional intake are met, documented and any concerns raised to the nurse. Residents are consulted daily in relation to their meal preferences and alternatives are offered by request.

Monthly resident forums are taking place.

The Provider confirms that 18 wats tanks have been installed in the centre. The tanks have been certified, and water quality testing has been completed. Water temperatures are logged weekly.

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

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Regulation 17: Premises

Not Compliant

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

The flooring to all communal areas will commence on 13th July with the second phase of the rooms commencing on completion. Phased work will ensure minimal risk and disruption to the residents. A full risk assessment will be completed prior to each phase of the works being undertaken. Following the completion of the flooring works a program of redecoration will take place throughout the centre. A date for commencement of the redecoration process will be informed to HIQA once the flooring has been completed.

A timeline for the refurbishment of the furnishings in each area of the centre will be provided to HIQA once the flooring and redecoration programs have taken place.

A new nurse call system has been put in place and a survey of the premises to highlight areas where additional calls bells are required.

GM has arranged for the roof cleaning and the removal of moss to take place. Completion scheduled for completion by the 30th June to ensure that the external environment is maintained accordingly to ensure sustained compliance the GM/PIC/CNM/Maintenance will complete monthly environmental audits and findings will be reviewed at management meetings and issued to the Provider.

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

Regulation 18: Food and nutrition	Not Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: The team has reviewed mealtime practices in conjunction with the residents, nutritional monitoring systems and care planning to ensure the residents nutritional needs are assessed and monitored A third dining area has been introduced to provide the residents with the choice as to where they wish to dine. Mealtimes have been staggered to ensure that residents who require assistance with eating and drinking receive support from staff in a calm and dignified manner. To ensure oversight of nutritional care all residents who are identified at risk of weight loss or poor intake are monitored and staff are assigned to assist with eating and drinking recording intake and escalation to the nurse of any concerns identified. A MUST assessment is completed on admission, or sooner if concerns are identified. Care plans are formulated and updated to reflect the individual residents changing needs. Weekly weights and daily food and fluid intake is monitored of those at clinical risk and referrals are made to the MDT where necessary. Reviews of care plans with the residents following any weight loss or deterioration in intake. PIC/CNM has oversight of the above. The resident identified during the inspection as having poor nutritional intake has had a full nutritional assessment and care plan implemented. The care plan has been developed with the residents in conjunction to their will and preference around food and fluid intake. Menus are displayed daily within each dining area. Desserts, snacks and drinks are served in a manner which supports the person-centred dining experience.	
Regulation 26: Risk management	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management: The risk management systems within the centre have been reviewed and strengthened to ensure they are comprehensive, consistent and effectively monitored with control measures in place.	

The risk management policy has been reviewed and updated to ensure it outlines the identification, assessment, recording and control measures of risks within the home. It includes the responsibility of all staff and clear escalation pathways so that risks are identified and notified to the management team in a timely manner. The risk register has been fully updated and maintained in both electronic and hard copy formats. Staff have been informed of their responsibility to identify and report risks as part of their daily working practice. This is reinforced at the daily safety pauses.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: All domestic staff have completed IPC training, and a program of refresher training has been scheduled. The training will include transmission-based precautions, standard precautions, environmental cleaning, hand hygiene, waste management and response procedures to an outbreak. IPC training has been scheduled for all staff on 26th May 2026. PIC has instructed staff to complete the HSE Land online training. An IPC Lead has been appointed and is responsible for the monitoring and improvement of IPC practices. The IPC Lead conducts three quarterly audits with the audit findings reviewed by GM/PIC/CNM. QIP is maintained with corrective actions responsible persons and timeframes for completion.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire doors are checked twice daily to ensure they are not obstructed and at fully functional. Any deficits identified are immediately escalated to the management team. A revised fire drill template is now being used and accurate records kept. Refresher fire training has been arranged for all staff with the emphasis on evacuation	

procedures, compartmentalization knowledge, the use of evacuation equipment, horizontal evacuation and the roles of relevant staff in the evacuation procedures.

Since inspection fire drills have been occurring weekly across all shifts including night simulations to ensure that staff can demonstrate competency during evacuation. The PIC/CNM/GM will complete competency assessments following fire drills to verify staff knowledge and to identify any additional gaps in knowledge.

Fire safety knowledge and emergency response responsibilities are discussed at daily handovers and safety pauses.

The PIC/CNM will continue daily walkabouts, attend handovers and safety pauses to maintain oversight of residents safety and any risks identified will be escalated accordingly and control measures put in place.

Formal reflective practice is now taking place and when a gap in learning is identified actions are taken to support staff development and to monitor development These measures are intended to provide stronger governance and reassurance that the staff have the knowledge skills and competence to maintain residents safety.

A fire-door survey has been completed and any recommendations will be responded to in a timely manner.

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

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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 care plans and assessments have been reviewed and named nurses are allocated to ensure that residents care plans and assessments are updated accordingly. Monthly care plan audits are carried out by PIC and CNM.

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Regulation 9: Residents' rights

Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:	
Since inspection the required divisional curtains have been ordered. The material is not available until June. An interim measure – privacy screen has been put in place to ensure individual resident privacy. Menus are displayed daily within each dining area. A new residents order list has been formulated to ensure that each resident has the right of choice for each meal. Desserts, snacks and drinks are served in a manner which supports the person-centred dining experience. CNM and nurse on duty have oversight of the above. We hold resident meetings monthly to discuss the Centre and any changes that are or will be taking place. This also gives the residents the opportunity to make suggestions as to things they would like changed or improved.	

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	30/04/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	16/05/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Red	25/02/2026

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Red	25/02/2026
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	30/04/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	30/04/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	30/04/2026

	effective delivery of care in accordance with the statement of purpose.			
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	25/02/2026
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Not Compliant	Orange	30/04/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/04/2026
Regulation 26(1)(f)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the audit, review and learning from events.	Not Compliant	Orange	30/04/2026

Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	30/04/2026
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.	Substantially Compliant	Yellow	20/05/2026
Regulation 27(c)	The registered provider shall ensure that staff receive suitable training on infection prevention and control.	Substantially Compliant	Yellow	28/05/2026
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	30/04/2026
Regulation 28(1)(b)	The registered provider shall provide adequate	Not Compliant	Orange	30/04/2026

	means of escape, including emergency lighting.			
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	Red	13/03/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/04/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Red	13/03/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means	Not Compliant	Red	13/03/2026

	of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	13/03/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/04/2026
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	30/04/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive	Substantially Compliant	Yellow	30/04/2026

	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.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/04/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/04/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities	Substantially Compliant	Yellow	28/05/2026

	for occupation and recreation.			
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	28/05/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/04/2026
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.	Substantially Compliant	Yellow	30/04/2026