



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

Issued by the Chief Inspector

Name of designated centre:	Brookhaven Nursing Home
Name of provider:	Brookhaven Nursing Home Limited
Address of centre:	Donoughmore, Ballyraggett, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	16 October 2025
Centre ID:	OSV-0000207
Fieldwork ID:	MON-0048471

About the designated centre

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

Brookhaven Nursing Home is situated in the village of Ballyragget, seven kilometres from the town of Durrow, Co. Kilkenny. The centre is registered to accommodate 71 residents, both male and female. It is a two-storey building but resident's accommodation and facilities are located on the ground floor; the staff changing facilities and offices are located upstairs. Residents' accommodation comprises single and twin bedrooms with en-suite shower and toilet facilities, two dining rooms, an activities room, sitting rooms and a sun room. There are comfortable seating alcoves throughout the centre and toilet facilities are strategically located for residents' convenience. Residents have access to five enclosed garden areas with seating and walkways. Other facilities include the main kitchen and a laundry. Brookhaven provides full-time nursing care for people with low to maximum dependency assessed needs requiring long-term residential, palliative, convalescence and respite care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64
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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
Thursday 16 October 2025	09:30hrs to 19:15hrs	Mary Veale	Lead
Monday 20 October 2025	10:35hrs to 16:50hrs	Mary Veale	Lead
Thursday 16 October 2025	09:30hrs to 19:15hrs	Laura Meehan	Support
Thursday 16 October 2025	09:30hrs to 19:15hrs	Marguerite Kelly	Support
Monday 20 October 2025	10:35hrs to 16:50hrs	Laura Meehan	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. On the first day, three inspectors attended the centre, with two inspectors returning four days later to complete the second day of the inspection. This inspection took place 17 days after the previous inspection of the centre and was carried out to assess whether the provider had taken appropriate action to address the significant findings of non-compliance identified during the September 2025 inspection of the centre.

Over the course of the inspection, the inspectors spoke with 10 residents, staff and visitors to gain insight into what it was like to live in Brookhaven Nursing Home. The inspectors spent time observing the residents' daily life in the centre in order to understand the lived experience of the residents. Residents and visitors expressed concerns relating to the centre being short-staffed, long waiting times for call-bells to be answered, and that areas of the centre remained cold, in particular some bedrooms and communal areas on Attanagh and Donoughmore wings.

On arrival at the centre on the first day, some residents were observed walking the corridors areas. Inspectors checked the temperature of the communal spaces near the reception area, the oratory and the relaxation/aromatherapy room. Inspectors found that these rooms continued to be cold throughout the inspection days. Inspectors observed that some areas of the premises were not maintained to an appropriate standard, nor were some communal areas and bedrooms decorated in a homely manner. Many bedrooms were observed not to be decorated with residents' personalised items or have decorative pictures or paintings, so as to create a pleasant environment. The inspectors observed that a sufficient supply of bed sheets was available, but many beds were observed to have a bottom sheet and not a top sheet in place.

Brookhaven Nursing home is located on the outskirts of the village of Ballyraggett in Co.Kilkenny. The centre comprises a two-storey building. The centre is registered to accommodate 71 residents. The first floor of the building is not part of the designated centre. The first floor contains the centre's administration office and staff changing facilities. The location and layout of the centre were generally suitable for its stated purpose. The outdoor spaces, including inner courtyards from each wing, were readily accessible and safe, making it easy for residents to go outdoors independently or with support, if required.

The inspectors spent time observing staff and residents' interactions. Larger groups of residents were observed sitting together in the day room of the Attanagh wing, participating in arranged activities. Small groups of four to five residents were observed sitting in the lounge in Kilminan wing and the sitting room in Rosconnell wing, with the television as the only form of stimulation. This is discussed under Regulation 9: Residents' rights.

Alcohol hand gel dispensers were readily available. However, the inspectors did not observe good hand hygiene practices during the days of inspection. Similar findings were also found on the previous inspection in September 2025. Since the previous inspection, the sluice room had been re-established on Kilminan wing, which had been in use as a cleaner's room. This is discussed further under Regulation 27: Infection prevention and control.

The inspectors observed the dining experience at lunch time on both days of inspection and saw that both the Ash and the Oak dining rooms were in use. The inspectors observed that the meals provided appeared appetising and were served hot. Most residents were complimentary about the food and confirmed that they were always afforded a choice and provided with an alternative meal should they not like what was on the menu. Adequate numbers of staff were available and were observed offering encouragement and assistance to residents. However, staff were observed during lunchtime applying their hair nets and also moving between residents without cleaning their hands. This can facilitate the spread of infectious agents. Furthermore, inspectors observed institutional practices where staff applied personal protectors/bibs to residents without asking for permission and using large spoons to assist residents to eat lunch. This did not support residents' choices and their right to dignity.

Residents had access to a timetable of activities. Over the course of the inspection, residents were observed attending a live-streamed Mass and a music session. A number of residents were seen attending a special ballot vote in the presidential election in the centre on the second day of inspection. Some residents who spoke with the inspectors said that they recently had limited access to planned activities due to staff leave. Improvements were required in activities, particularly to the residents' experience and the environment in which activities are undertaken. This is discussed under Regulation 9: Residents' rights.

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

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 to 2025 (as amended). The inspection has included a review of actions taken by the provider in response to two urgent compliance plans issued to the provider following the inspection of the centre on 24 September and 29 September 2025. These compliance plans required the provider to take action in relation to governance & management, premises, infection prevention and control, and medication management.

In addition, inspectors reviewed unsolicited information received by the Office of the Chief Inspector concerning the quality and safety of care provided to residents. This information related to concerns in areas of personal care, nutrition and hydration, care planning, complaints management, staffing and governance and management. The inspection was carried out in response to serious and escalating concerns regarding the safety and well-being of residents in the centre, which were identified during the inspection completed in September 2025. The urgent compliance plans submitted by the provider following the September inspection were not accepted by the Chief Inspector.

Brookhaven Nursing Home Limited is the registered provider for this centre. At the time of inspection, there were four directors in the company. The centre is part of a group of five nursing homes and has access to group resources, such as finance, human resources and facilities management. The person in charge (PIC) has a team consisting of an assistant director of nursing (ADON), a clinical nurse manager (CNM), registered nurses, health care assistants, kitchen staff, housekeepers, activities staff, administration and maintenance staff. On the first day of inspection, the PIC was on planned leave, and the ADON was deputising for the PIC. The CNM was also on planned leave, and a staff nurse was deputising for the CNM. The senior management team were in the centre when the inspectors arrived on the second day of inspection. The inspectors were not assured that sufficient staff were on duty during the days of this inspection. This is outlined in Regulation 15: Staffing.

Documentation, safeguarding and challenging behaviour training had taken place since the previous inspection. Infection prevention and control (IPC) training was booked to take place in the weeks following the inspection. While there were improvements to the training matrix and staff training was up to date, further assurances were required to ensure that staff were appropriately supervised. This is discussed further under Regulation 16: Staff training and development.

This inspection found that the registered provider had failed to put in place sufficient resources and management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored. The impact of this was found in the sub-standard care delivered to residents, which significantly impacted their safety, well-being and their quality of life. There had been two staff meetings since the September 2025 inspection. One meeting required mandatory attendance by staff, and a suggestion box had been set up in the staff room following the meeting to allow staff to submit suggestions and improvements following the poor findings of the previous inspection. The ADON had undertaken a weekly out-of-hours, IPC and medication management audits as well as an analysis of wounds since the September 2025 inspection.

Regulation 15: Staffing

The registered provider had failed to ensure that the number and skill-mix of staff were appropriate for the assessed needs of the residents. From a review of the rosters, it was evident that;

- Vacant shifts in the health care assistant staff roster resulted in nursing staff covering these shifts. This impacted the overall supervision of staff, and the supervision of the quality of care provided to residents.
- Health care assistants were allocated to the provision of activities to support the residents to participate in activities due to planned leave. As a result, some planned activities for residents were suspended. Residents informed the inspectors that they felt the day was very long.
- Residents were observed waiting long periods of time for assistance for their call-bells to be answered.

Judgment: Not compliant

Regulation 16: Training and staff development

Action was required to ensure that all staff received refresher mandatory training. For example;

- Assurances were provided to the office of the Chief Inspector that all staff had attended refresher manual handling training following a serious event. On review of the trainings records provided to the inspectors only six staff had completed this refresher training.

Staff were not adequately supervised to ensure they implemented local policies and procedures and adhered to best evidence-based practice in respect of upholding residents' rights and providing safe care and reducing the risk of harm to the residents. For example:

- There was evidence of incorrect practices in the area of infection prevention control, including the poor adherence to hand hygiene and personal protective equipment (PPE) practices. This was a repeated finding on the previous inspection.
- There was evidence of incorrect manual handling practices. This was evident in the damage observed to the premises and equipment used for manual handling of residents. One resident was observed in a distressed state while being assisted to mobilise with a manual handling hoist.
- During the inspection, staff were observed to provide assistance to the residents in a task orientated manner with little or no interaction with the residents.

Judgment: Not compliant

Regulation 23: Governance and management

On the first day of the inspection, due to a significant risk identified by the inspectors, an immediate action plan was issued to the provider relating to an individual care plan. Inspectors were informed during the closing meeting on the first day of inspection that a resident's care plan had been formally reviewed in consultation with the resident. It was evident from the nursing documentation on the second day of inspection that the resident's care plan had not been fully reviewed.

Action was required by the registered provider to ensure that there was sufficient resources to provide the effective delivery of care in accordance with the statement of purpose. The provider was required to maintain staffing in line with the statement of purpose, Brookhaven Nursing Home Limited was registered against. Rosters provided to the inspectors on the days of inspection evidence that there were staff vacancies in nursing and healthcare assistant roles. The statement of purpose, which Brookhaven Nursing Home Limited was registered against states that there should be:

- 12 whole time equivalent (WTE) nurses posts. There was 1 WTE nursing post vacant at the time of inspection.
- 7 whole time equivalent (WTE) senior health care assistant posts. There were 3 WTE senior healthcare assistant posts vacant at the time of inspection.
- 30 whole time equivalent (WTE) health care assistant posts. There were 7 WTE healthcare assistant posts vacant at the time of inspection.

The overall governance and management of the centre was not fully effective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example: the provider had not been transparent in its communication with the inspectors on the previous inspection in relation to the management of a serious incident within the centre.

There were inadequate systems of oversight in place to monitor and respond to issues of concern found by the inspectors, particularly in relation to care planning, healthcare, safeguarding, residents rights, the premises, infection prevention and control, and medication management. These issues are discussed further under Regulation 5; Individual assessment and care planning, Regulation 6: Healthcare, Regulation 8: Protection, Regulation 9: Residents rights, Regulation 17: Premises, Regulation 27: Infection control and, Regulation 29: Medicines and pharmaceutical services.

The oversight and monitoring of incidents and accidents was inadequate. There was a failure to provide a full disclosure of an event resulting in a serious injury of a resident. Strengthened oversight was required to ensure that the appropriate incidents were notified to the office of the chief inspector. This is discussed further under Regulation 31: Notification of Incidents.

These were repeated findings following the September 2025 inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the records in relation to recent deaths in the centre showed that there were incidents as set out in Schedule 4 of the regulations that were not notified to the office of the Chief Inspector within the required time frames. The provider submitted these notifications retrospectively following the second day of inspection at the request of inspectors.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspectors informed the nominated complaints officer that a resident wished to meet the nominated complaints officer on the last day of the September 2025 inspection to make a complaint of an issue of concern that had occurred. The nominated complaints officer had not met the complainant to investigate the complaint.

The registered provider had not ensured that the nominated complaints officer had received suitable training to deal with complaints. The registered provider had not ensured complaints were managed in accordance with the timelines set out in the providers policy and regulatory requirements.

Judgment: Not compliant

Quality and safety

The overall quality and safety of care continued to be impacted by ineffective governance and management systems. Inspectors found that ineffective management and supervision of the staff impacted the quality and safety of care being delivered. As a result, care and support needs were not always provided in line with residents' care plans. The assessment of residents' needs was inadequate and did not ensure the delivery of safe, high-quality, person-centred care to residents. Non-compliance in relation to individual assessments and care plans,

health care, safeguarding, residents' rights, the premises, infection prevention and control, and medication management impacted on residents' safety and well-being.

The inspectors reviewed a sample of residents' notes and care plans. Overall, the standard of care planning required improvement to ensure that it was accurate and updated to guide safe and effective care. Details are presented under Regulation 5: Individual assessment and care plan.

Residents had access to general practitioners (GP) from local practices, specialist services and health and social care professionals, such as psychiatry of old age, physiotherapists, dietitians and speech and language therapists, as required. Residents had access to a mobile X-ray service referred by their GP, which reduced the need for trips to the hospital. Residents had access to local dental and pharmacy services; however, access to a tissue viability nurse was only available remotely. Residents who were eligible for national screening programmes were also supported and encouraged to access these. Despite having access to these services, further improvements were required in healthcare. This is discussed further under Regulation 6: Healthcare.

Maintenance works to repair the centre's heating system were underway during this inspection. Improvements required to the premises are outlined under Regulation 17: Premises.

Residents who were affected by scabies were found to have completed the required period of isolation, and improvements were found in the storage of residents' laundry. On this inspection, parts of the centre and equipment were found to be dirty. Several poor practices were found. Issues pertinent to infection prevention and control are set out under Regulation 27: Infection control.

There was a comprehensive centre-specific policy in place to guide nurses on the safe management of medications. Controlled drugs balances were observed to be checked at each shift change since the previous inspection as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving. However, further improvements were required in the storage of medications, which has remained unchanged since previous inspections. This is discussed further under Regulation 29: Medicines and pharmaceutical services.

Regulation 12: Personal possessions

The person in charge had not ensured that residents on Kilminan wing has access and control of their personal possessions. For example:

- Residents clothes were observed to be stored in an unregistered part of the designated centre which residents did not have access to.

Judgment: Substantially compliant

Regulation 13: End of life

The person in charge had failed to ensure that residents received appropriate care and comfort which addressed their physical, emotional, social, psychological and spiritual needs. For example:

- Not all residents had access to palliative care or end of life measures from a holistic person-centred perspective and in a dignified manner.
- The end of life wishes of residents and their representatives were not clearly set out within personal plans

Judgment: Not compliant

Regulation 17: Premises

The registered provider did not ensure the premises of the designated centre were appropriate to the needs of the residents and in line with the statement of purpose. For example:

- Two day-rooms and the conservatory were not accessible to residents on both days of inspection due to the cold temperatures in these rooms. This was despite plug in radiators being available for use.
- The oratory was not available as work was being completed to the heating system and relaxation/aromatherapy rooms were not available to residents as the temperature of this room was cold at times during the inspection.
- There was evidence of inadequate storage measures within the centre. For example, a wooden frame for parties continued to be stored in a visitors room.

Parts of the premises did not conform to the matters set out in Schedule 6 of the regulations, for example, but notwithstanding;

- A review of all televisions in the bedrooms was required as a number of televisions were found not to work or the remotes controls were not working. Residents reported not being able to watch their favourite shows.
- There was significant wear and tear, and damage to the walls beside beds and to the door frames of some bedrooms.
- The bed in bedroom 49 required repair.
- One of the two toilets adjacent to the Oak dining room remained out of order.

Judgment: Not compliant

Regulation 18: Food and nutrition

While residents were observed to be offered a choice at mealtimes, action was required to ensure the residents and staff were aware of the meal choice being offered. For example:

- Some residents told the inspectors that they were confused as to which weeks menu was on offer.
- Inspectors observed staff offering residents a choice of meal which was not on offer on the second day of inspection.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider did not meet the regulatory requirements and the National Standards for infection prevention and control in community services (2018). For example:

- Since the previous inspection the recently reconfigured sluice room on Kilminan wing which had been taken out of service now contained a bed pan washer/disinfector. However, the unit failed to operate during testing conducted on the first day of the inspection. The repeated failure of the bed pan and urinal washer/disinfector machines creates an ongoing infection control risk for both residents and staff. Without these decontaminating devices, the provider cannot ensure the disinfection of items like bedpans and urinals, leading to increased risk of infection. Additionally, the provider had not fitted further equipment needed for the function of this room. For example; wall rack for bedpans and urinals with drip tray and bedpans and urinals for resident use.
- The management of sharps was not in line with best practice guidelines. For example; staff were using an incorrect sharps container for the disposal of sharps. Additionally, sharps boxes seen were not signed on assembly. The signature on a sharps bin acts as a confirmation that it has been correctly and safely assembled according to the manufacturer's instructions. Poor sharps management was similarly discussed at a staff meeting held in Sept, 2025.
- The cleaner's room contained unclean equipment. For example; an unclean hand wash sink and two floor cleaners were seen stored with unclean water left in the tanks. Stagnant water and unclean equipment create an opportunity for bacteria to grow, increasing the risk of cross contamination for residents.

- There were dedicated nurse's room for the storage and preparation of medications, clean and sterile supplies such as needles, syringes and dressings. There were hand washing sinks available, but not compliant as outlined in HBN 00-10 Part C Sanitary Assemblies which is the standard required for sanitary ware. Dressing trolleys seen in the clinical rooms were already prepared and stocked with items required for dressings. This posed a risk of contamination of the sterile supplies on these trolleys. Additionally, single use wound dressings and a large packet of cotton wool was seen open and partially used. This may impact the sterility and efficacy of these products. Similar findings were found during the centres own walk around audit on the 13.10.25.
- Also observed on the medication trollies were yogurts pots both open and unopened used in the administration of medications. Open yoghurt's should be discarded after the medication round has finished and unopened yoghurt's should be stored in a fridge not left at room temperature, as harmful bacteria can grow rapidly at incorrect temperatures.
- Accurate surveillance of multi-drug resistant organism (MDRO) colonisation was not undertaken. As a result, there was some ambiguity among staff and management regarding which residents were colonised with MDROs. A review of documentation and discussions with staff found that staff were unaware of two resident's correct status of Carbapenemase-Producing Enterobacterales (CPE). As a result accurate infection prevention and control information was not recorded in these care plans to effectively guide and direct their care.
- Several nebuliser compressor machines seen were unclean and not maintained as per manufactures instructions. Nebuliser medication chambers were not cleaned and dried as per best practice guidelines and the white filters were discoloured.
- Resident equipment was seen stored inappropriately for example hoist slings in a basket within a nurse management office and a pressure relieving cushion was seen on a resident's dining table. Equipment was seen stored unclean including crash mats, pressure cushion, wheelchairs and a shared, ear thermometer. The thermometer was heavily stained with a wax like substance and there was no indication that single use probe covers were in use. This is a significant IPC risk, as it can transmit germs and cause infections. It's vital to use a new disposable probe cover for each use and to thoroughly disinfect the thermometer between uses, especially the sensor and any parts that have touched skin.
- Include dirty cushion near bedroom 40.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Practices observed in relation to the storage and use of some medications were not in line with best-practice medicines guidance. For example;

- Medications were stored inappropriately in an unsafe manner. For example, prescribed topical medication was found in a box on the counter of the nurses station in Kilminan wing. Mouth care boxes stored at the nurses stations in both Kilminan and Donoghmore wings both contains out- of date medicated swabs.
- There were inaccurate records for the administration of prescribed medication i.e. eye drops.
These were repeated findings on the previous inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- One resident did not have pre-admission assessment available.
- Some care plans assessments were found to be inaccurately recorded or not fully completed, therefore, they could not inform care delivery. For example, a male resident who was recently admitted to the centre, had incorrect personal details and was documented as admitted to another designated centre.
- One resident who had bed-rails in use, did not have a specific care plan for bed-rails.
- Care plans required review to ensure a specific and person-centred approach to care was provided. A sample of care plans viewed were not sufficiently detailed or person centred to guide staff on the care of residents. Of the sample of care plans viewed, many were generic with pre-populated interventions which were not reflective of the needs of the individual resident's.
- Discrepancies were found between the care plans and the progress notes for a number of dietary and fluid consistency care plans for residents. For example; a care plan outlined clear instructions on a level 5 consistency for food and a level 0 for fluids as per the International Dysphagia Diet Standardisation Initiative (IDDSI) framework. However; the progress notes stated that the resident was on a level 6 consistency for food and a level 2 for fluids. The risks of being on the wrong consistency diet, particularly for individuals with swallowing difficulties, include choking, aspiration pneumonia, dehydration, malnutrition, and weight loss.
- Discrepancies were found in care plans relating to end of life care.
- One resident who had a care plan for a nephrostomy tube, did not have a nephrostomy tube in place.
- A resident who had a colostomy did not have sufficient detail included in their care plan to guide staff on how to manage the colostomy.

There was inconsistent guidance for staff on the support needs for residents including in the area of manual handling. For example, one resident's plan stated two staff required for transfers, in the next paragraph it stated one staff for support.

Judgment: Not compliant

Regulation 6: Health care

Notwithstanding residents' access to a range of healthcare professionals, significant robust action was required to ensure that all residents had timely access to appropriate medical and healthcare based on their assessed needs and a high standard of evidence-based nursing care. For example:

- A resident did not have timely access to a medical review of their condition following detection of signs and symptoms of physical deterioration. The lack of timely access to a medical review can lead to delayed diagnosis and treatment of healthcare needs for the resident concerned.
- The provider had failed to identify that a resident was severely dehydrated in the centre. The resident required transfer to hospital and administration of intravenous fluids.
- Two residents who were at risk of dehydration did not have accurate fluid balance records. There were gaps noted in the records and a number viewed had not been calculated to assess or monitor the residents hydration status.
- A resident who had a pressure ulcer did not have a wound assessment completed. Nursing staff were not effectively monitoring the healing progress of the pressure ulcer.
- A sensor alarm mat was observed placed directly on a mattress with only a sheet between the resident and the alarm mat. Laying on a sensor alarm mat can pose risks such as skin damage (pressure sores, burns, shear), reduced airflow and increased moisture.

Judgment: Not compliant

Regulation 8: Protection

An incident which had been notified to the Office of the Chief Inspector by the registered provider in August 2025. At the time of this inspection the investigation had not commenced and required review.

This was a repeat finding from the September 2025 inspection which had yet to be addressed by the provider despite the serious nature of the allegation.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' right to exercise choice was not always upheld by the registered provider. For example;

- Residents had restricted access to the sitting rooms near reception and the oratory. The room temperature of these rooms was cold over the course of the inspection. This was a repeated finding on the previous inspection.

There was an overall lack of meaningful activities available for residents in the centre, which meant that, for the most part, residents were not participating in activities of interest to them. For example:

- Inspectors observed residents with high-dependency needs left with no attention from staff members for a long time, and there were no activities provided for residents who stayed in their bedrooms or those who used the sitting room on the Kilminin and Rosconnell wings.

Residents' right to dignity was not upheld by the registered provider. For example;

- As part of the dining experience inspectors observed staff put food protectors on residents without consultation or communication. This not in line with a person-centred approach to care delivery.

Residents were not sufficiently consulted about and the organisation of the centre. For example;

- The most recent residents' meeting was attended by only 12 residents, which represents 19% of the current occupancy. There was no evidence that residents who could not attend, due to preference or ability, were consulted with in another format or manner.

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 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Brookhaven Nursing Home OSV-0000207

Inspection ID: MON-0048471

Date of inspection: 20/10/2025

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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ul style="list-style-type: none"> • Staffing arrangements have been reviewed and strengthened to ensure they are appropriate to meet the assessed needs of residents. Nursing staff no longer routinely cover health care assistant (HCA) vacant shifts, ensuring appropriate clinical supervision, leadership presence, and oversight of care delivery. Recruitment of HCAs is ongoing on a continuous basis, and current HCA staffing levels are sufficient to meet the current number of residents and their assessed dependency levels. Recruitment continues to ensure resilience and sustainability of staffing arrangements. • Recruitment of dedicated activities staff is also ongoing. A second dedicated activities staff member has been recruited, enhancing social engagement and meaningful occupation for residents. In the event of unexpected absence, some HCAs may be rostered to support activities; however, where this occurs, they are rostered solely to the activities role for that shift and do not undertake a dual HCA and activities role on the same day. • A full upgrade of the call bell system has been actioned and is scheduled for completion by 15 January. Weekly audits of call bell response times have been implemented to monitor responsiveness and identify any delays. CNMs also review call bell response times daily during walkabouts, with immediate corrective action taken with the staff on duty where delays are identified. Audit findings are reviewed with staff on the day and at staff meetings to ensure accountability and support continuous improvement. Any persistent delays trigger an immediate review with the staff involved, with actions implemented and monitored to prevent recurrence. 	

Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <ul style="list-style-type: none"> • All staff have now completed refresher manual handling training, and training records have been reviewed to confirm compliance. Any new staff members are required to complete manual handling training as part of their induction prior to commencing duties in the centre. • Staff competency and practice are now closely supervised by management to ensure local policies and procedures are followed and that best evidence-based practice is consistently upheld. • All staff have completed Infection Prevention and Control (IPC) training. In addition, on-the-floor training was delivered across six dates during November and December, covering day, evening, and night shifts. This hands-on training included direct observation of staff practices relating to hand hygiene and the use of personal protective equipment (PPE). Any poor practice identified was corrected immediately at the point of care. Regular hand hygiene audits are now completed, with immediate feedback also provided to staff. Where non-compliance is identified, correct techniques are demonstrated immediately with the staff member to reinforce learning and compliance. • Manual handling practices were also observed as part of the hands-on training. Feedback was provided to staff, and observations were acted upon, with improvements implemented where required. In addition, manual handling practices continue to be routinely observed by management to ensure correct techniques are used, equipment is applied safely, and residents are supported in a safe and dignified manner. • Staff are guided and supported to deliver care in a person-centred way, with emphasis on communication, consultation, and respectful interaction during care delivery. Face-to-face coaching and on-the-floor training are provided during daily work practices, using live examples to reinforce learning and promote continuous improvement. • Ongoing management oversight, audit, and supervision are embedded to ensure sustained compliance with Regulation 16 and to reduce the risk of harm to residents. 	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- The immediate action plan issued during inspection in relation to an individual resident's care plan has been addressed. The resident's care plan has now been fully reviewed and updated in consultation with the resident, with management oversight to ensure documentation accurately reflects care delivery. Systems have been strengthened by the new Person in Charge to verify that actions reported to inspectors are fully completed and evidenced in nursing documentation.

- Recruitment and retention of staff are a continuous priority, and staffing arrangements are kept under ongoing review with the PIC and HR Department to ensure alignment with the Statement of Purpose and residents' assessed needs.

Where vacancies are identified on rosters, these shifts are covered to ensure safe care delivery, with the use of repeat agency staff where required to promote continuity, familiarity, and consistency of care.

Since the time of inspection, significant progress has been made in the recruitment of nursing and healthcare assistant staff, reducing reliance on temporary cover, there has been 3 nurses, 10 healthcare assistants, an activities co-ordinator, household assistant, kitchen assistant and administrator for the home recruited, onboarded and inducted in their respective roles. Recruitment remains ongoing for registered nurses and healthcare assistants.

- Since the time of the inspection, governance arrangements within the centre have been strengthened, including the appointment of a new Person in Charge (PIC).

The newly appointed PIC has responsibility for ensuring effective oversight, clear accountability, and transparent communication with regulatory authorities. Systems have been reviewed and reinforced to ensure that all incidents, concerns, and management actions are escalated appropriately, managed in line with regulatory requirements, and communicated openly and accurately to inspectors.

Governance and management systems are now subject to enhanced oversight through regular management meetings, clinical governance review, and provider-level monitoring to ensure the service is safe, appropriate, consistent, and effectively monitored. These arrangements are in place to ensure transparency, accountability, and sustained compliance going forward.

- Actions taken to address the specific issues identified by inspectors in relation to care planning, healthcare, safeguarding, residents' rights, the premises, infection prevention and control, and medicines management are detailed within the responses provided under Regulation 5 (Individual Assessment and Care Planning), Regulation 6 (Health Care), Regulation 8 (Protection), Regulation 9 (Residents' Rights), Regulation 17 (Premises), Regulation 27 (Infection Control), and Regulation 29 (Medicines and Pharmaceutical Services) of this report. Under the oversight of the newly appointed Person in Charge (PIC), governance systems have been strengthened to ensure ongoing monitoring, audit, and review across all regulatory areas and additional oversight by the Provider at both weekly and monthly Governance and Management Meetings.

- A full review of the incident was completed during the inspection, and full disclosure was provided to the Office of the Chief Inspector by the newly appointed Person in Charge (PIC).

All incidents requiring notification under Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have now been submitted.

Since the appointment of the newly appointed PIC, governance and oversight arrangements have been strengthened to ensure that incidents are identified, reviewed, disclosed appropriately, and notified to the regulator in line with statutory requirements. The PIC will ensure that all required statutory notifications are submitted accurately and within the required timeframes going forward, with provider-level oversight in place to ensure sustained compliance with Regulation 31.

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Regulation 31: Notification of incidents

Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

- All incidents requiring notification under Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have now been submitted.
- Since the appointment of the newly appointed Person in Charge (PIC), robust governance and oversight arrangements have been put in place, and the PIC will ensure that all required statutory notifications are submitted accurately and within the required timeframes going forward.

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Regulation 34: Complaints procedure

Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- The newly appointed Person in Charge (PIC) is now the nominated Complaints Officer for the centre and has taken responsibility for ensuring that all concerns and complaints raised by residents, both historical and new, are managed in line with Regulation 34 and the provider's complaints policy. To ensure residents are fully aware of how to make a complaint, complaints information posters are now prominently displayed throughout the centre and clearly outline the complaints process, including who residents can speak to and how concerns can be raised. The posters include the name and photograph of the PIC as the nominated Complaints Officer. The PIC has formally introduced herself to residents during resident meetings, where the complaints process was explained in a clear and accessible manner. In addition, the PIC engages with residents on a daily basis,

providing ongoing reassurance and reminders that concerns can be raised at any time. • All complaints are now formally recorded in the complaints register and are acknowledged, investigated, responded to, and closed within the required timeframes. Any historical complaints that come to the attention of the PIC are also reviewed and managed appropriately. Where a complaint cannot be resolved within the specified timeframe, the complainant is informed of the reason for the delay and provided with regular updates, in line with regulatory requirements.

- The registered provider has ensured that the newly appointed PIC has appropriate training in complaints management. Complaints are reviewed as part of the governance framework on both weekly and monthly management meetings to support learning and service improvement, with oversight maintained by the Provider Representative to ensure ongoing compliance.

Regulation 12: Personal possessions	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 12: Personal possessions:

- All residents’ personal belongings are now stored within registered areas of the designated centre and are fully accessible to residents. No personal items are stored in unregistered parts of the building, ensuring residents have access to and control over their personal possessions at all times, in line with regulatory requirements.

Regulation 13: End of life	Not Compliant
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Outline how you are going to come into compliance with Regulation 13: End of life: The registered provider acknowledges the inspectors’ findings in relation to end-of-life and palliative care.

- End-of-life care planning to include palliative care access has been reviewed and strengthened to ensure that residents receive care and comfort that addresses their physical, emotional, social, psychological, and spiritual needs in a dignified, person-centred manner.
- Care plans for all residents are now reviewed and updated to clearly document individual end-of-life wishes, with involvement from residents and, where appropriate, their representatives.

- Staff are supported through regular supervision, observation, and guidance to ensure a holistic approach is consistently applied to all aspects of end-of-life care, with ongoing discussion and support provided during team meetings.
- To further support staff understanding and practice, education in advanced care planning and end-of-life care is being enhanced, including participation in HSE-supported programmes focused on person-centred palliative care, commencing on 5 February, to support continued development in high-quality, person-centred end-of-life care.

Regulation 17: Premises	Not Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:

- All communal areas, including both sitting rooms and the conservatory, are now fully accessible to residents at all times. These areas are adequately heated, and in regular use by residents. The oratory and the aromatherapy/relaxation room are also now available for residents' use.
- In relation to storage, the wooden frame previously stored in the visitors' room has been removed, and appropriate external storage has been installed to ensure internal spaces remain free from inappropriate storage.
- A full audit of televisions and remote controls has been completed, and all occupied bedrooms now have fully functioning televisions and remote controls, ensuring residents can access their preferred programmes.
- General wear and tear and damage to walls besides beds and door frames identified during the inspection are being addressed as part of the ongoing maintenance programme. An audit of each room has been completed and a programme of works ongoing.
- Repairs to the bed in Bedroom 49 have been completed.
- Works are currently ongoing to reinstate the full functionality of the toilet adjacent to the Oak dining room.

Regulation 18: Food and nutrition	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

- The format for displaying menus has been reviewed and updated, and the previous practice of displaying a full monthly menu has been discontinued. Menus are now displayed daily, clearly outlining the meal choices available for that day only, to ensure clarity for residents and staff.
- Food is served in line with the displayed daily menu, and where a resident does not wish to choose from the menu of the day, alternative options are provided to respect individual preferences.
- Feedback on food quality, menu choice, and menu display is gathered daily through informal discussions with residents, and residents are regularly asked if they are satisfied with the meals offered. Feedback is also discussed and reviewed at monthly residents' meetings and is used to inform ongoing improvements.

Regulation 27: Infection control

Not Compliant

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

- The Kilminan Wing sluice room is now fully operational. The bedpan washer/disinfector has been repaired and tested on multiple occasions by the Facilities Manager and is functioning correctly. Required equipment, including a wall-mounted rack and drip tray, has been installed. Ongoing monitoring is in place by the local management team to ensure sustained functionality and compliance.
- Sharps management has been reviewed and reinforced. Correct sharps containers are now in use, all sharps boxes are signed on assembly, and compliance is monitored regularly by management. This has been reiterated with staff to ensure adherence to best practice and manufacturer guidance.
- The issues identified in the cleaner's room has been addressed. All cleaning equipment is now cleaned after use, water tanks are emptied and dried, and sinks are maintained in a clean condition. Management completes regular checks to ensure cross-contamination risks are prevented.
- A review of hand-washing sinks throughout the building is currently underway by the Facilities Manager, with findings to be reviewed and actioned as required. Dressing trolleys are no longer pre-stocked and are prepared immediately prior to use. All single-use dressings and cotton wool are discarded after use, with regular management checks in place to ensure ongoing compliance. Findings from internal audits have been actioned and re-audited to confirm improvement and sustained practice.
- Medication trolleys are now managed in line with IPC guidance. Open yoghurt pots are

discarded immediately after medication rounds, and unopened yoghurts are stored in a refrigerator until required. Staff compliance is monitored by CNMs.

- MDRO surveillance has been strengthened since the inspection. MDRO status is accurately recorded in residents' care plans, highlighted during daily handovers, and clearly communicated to nursing, healthcare, household, and kitchen staff. Any active infection or colonisation is discussed daily to ensure appropriate infection prevention and control precautions are implemented.
- Nebuliser equipment is now cleaned, dried, and maintained in line with manufacturer instructions and best practice guidance. Filters are replaced as required, and cleaning schedules are in place and monitored.
- Resident equipment storage and cleanliness has been addressed. Hoist slings are stored in residents' rooms as appropriate, pressure-relieving cushions have been reviewed, non-compliant cushions discarded, and new cushions ordered and received. All cushions and shared equipment are cleaned regularly in line with IPC schedules.
- Clinical equipment, including thermometers, wheelchairs, walking frames, and crash mats, is cleaned according to a documented cleaning schedule. A new ear thermometer has been ordered and received, single-use probe covers are in stock, and staff have been instructed and observed to use them correctly at all times.
- Ongoing management oversight, audits, and staff education are in place to ensure sustained compliance with Regulation 27.

Regulation 29: Medicines and pharmaceutical services	Not Compliant
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- A full medication audit has been completed across the centre by the new Person in Charge, and all expired or out-of-date medications were immediately removed and safely discarded.
- All medications, are now stored appropriately, securely, and under lock, in line with best-practice medicines management guidance.
- Mouth care boxes at all nurses' stations have been reviewed, with any out-of-date medicated swabs removed and replaced as required. Medications are no longer stored on counters or in unsecured areas.
- Medication Administration Records (MARs) are now reviewed routinely by nursing management. Any discrepancies identified are documented, escalated, investigated, and

addressed promptly.

- Monthly medication audits are in place and completed jointly by nursing management and the contracted pharmacy. Audit findings are reviewed as part of the clinical governance framework, with actions implemented and monitored to ensure sustained compliance and prevent recurrence.
- Ongoing staff supervision, training, and audit oversight are embedded within governance arrangements to ensure continued compliance with Regulation 29 and best-practice medicines management. Audit findings and any issues identified are discussed at RGN meetings and are can also be highlighted during daily handovers or through one-to-one discussions with individual RGNs to support immediate learning and corrective action.

Regulation 5: Individual assessment and care plan

Not Compliant

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

- A full review of pre-admission assessments has been completed, and the newly appointed PIC will ensure moving forward all residents will have a pre-admission assessment scanned and uploaded to the electronic system.
- A comprehensive review of all assessments and care plans has taken place to ensure accuracy, completeness, and relevance. Incorrect personal details and documentation errors have been corrected.
- The resident who had bed rails in use with no care plan, now has a specific care plan in place.
- Care plans have been updated to reflect individual, person-centred needs, with removal of generic, pre-populated interventions. All care plans now provide clear guidance to inform care delivery.
- Dietary and fluid consistency care plans have been reviewed and aligned with IDDSI guidance, with discrepancies between care plans, progress notes, and diet lists corrected to ensure resident safety.
- End-of-life care plans have been fully reviewed and updated, with residents' and representatives' wishes clearly documented to support dignified, person-centred care.
- Care plans relating to clinical devices (e.g. nephrostomy tubes and colostomies) have been reviewed to ensure accuracy, relevance, and sufficient detail to guide staff practice.

- Manual handling guidance within care plans has been standardised to ensure consistent and clear instructions for staff.

Under the oversight of the newly appointed Person in Charge (PIC), assessments and care planning processes have been strengthened to ensure consistent and ongoing improvement across all residents' care plans. Multidisciplinary Team (MDT) reviews are conducted regularly to ensure assessments, care plans, and diet lists remain accurate, current, and clearly communicated to all staff. Resident and family meetings to review care plans are ongoing, with approximately 80% completed to date and the remaining reviews scheduled. Ongoing management audits, PIC oversight, and governance review are in place to ensure sustained compliance with Regulation 5 and to support continuous improvement.

Regulation 6: Health care	Not Compliant
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Outline how you are going to come into compliance with Regulation 6: Health care:

- Processes for escalation and access to medical assessment have been reviewed by the Provider and strengthened to ensure residents receive prompt review based on their assessed needs.

Arrangements for medical cover have been enhanced to improve access to timely medical advice and review, including the availability of additional medical support where required. Clear escalation pathways are now in place to ensure that any signs of deterioration are acted upon immediately, with appropriate clinical decision-making, including escalation to out-of-hours services or hospital transfer where necessary. Nursing staff have been reminded of their responsibility to escalate concerns promptly to the PIC/CNM and to document all actions taken. Oversight by nursing management ensures that medical reviews are requested, followed up, and actioned without delay.

- Hydration assessment and monitoring practices have been reviewed by the PIC and reinforced. All residents identified as being at risk of dehydration now have accurate fluid balance charts in place, which are completed, calculated and reviewed daily by nursing staff. Any concerns regarding hydration status are escalated promptly for clinical review to the PIC. Staff are supervised by the CNM and continued guidance is provided to ensure residents' hydration needs are met and monitored effectively.
- Wound care management has been strengthened to ensure all pressure ulcers are assessed, documented, and monitored in line with best practice. Wound assessments are now completed promptly, with care plans reviewed regularly to monitor healing progress and ensure appropriate interventions are in place. Referrals to the Tissue Viability Nurse (TVN) are made as required and recommendations implemented.

- Sensor mats are now used strictly in accordance with manufacturers' guidance and best-practice recommendations.

Regulation 8: Protection	Not Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection:

- The registered provider acknowledges the inspectors' findings in relation to the safeguarding incident notified in August 2025 and the delay in commencing the investigation.
- The safeguarding incident has now been formally investigated by an Independent Clinical Consultant to ensure objectivity, transparency, and compliance with safeguarding requirements.
- Safeguarding governance and oversight arrangements have been strengthened since the Inspection to ensure that all safeguarding concerns are commenced, investigated, actioned, and closed within the required timeframes. Clear accountability and escalation pathways are now in place to ensure no safeguarding concern remains outstanding.

Regulation 9: Residents' rights	Not Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

- Both sitting rooms near reception and the oratory are now adequately heated, and accessible to residents at all times.
- The activities service has been strengthened, with two dedicated activity staff now in place and recruitment ongoing for a third team member. A full review of the activities programme has been completed and is reviewed regularly to ensure it reflects residents' interests, preferences, and abilities. This information has been gathered through residents' meetings and one-to-one discussions with residents. In addition, resident surveys are currently underway to gather further feedback. Activities are now varied in nature and inclusive, with specific consideration given to residents with high-dependency needs and to those who prefer to remain in their bedrooms, ensuring all residents have opportunities for meaningful engagement.
- The dining experience is now closely monitored by management. Staff are observed and guided to ensure consultation and communication with residents takes place at all times, including seeking consent before the use of food protectors, in line with a person-centred and dignified approach. Dining experience audits are completed regularly, with

findings reviewed and actions implemented to support ongoing improvement.

- Resident consultation has been strengthened to ensure all residents have an opportunity to express their views. Two resident representatives have been identified to support residents who choose not to attend meetings or are unable to do so, ensuring their wishes, preferences, and concerns are represented. These representatives may raise issues during meetings or directly with the Person in Charge at any time.

In addition, residents who do not wish to attend meetings are offered copies of the meeting minutes, should they wish to receive them. Where residents would like to provide feedback but prefer not to attend meetings, their views are gathered in advance and raised on their behalf at the residents' meeting.

The Person in Charge also carries out regular individual visits with residents, particularly those who remain in their bedrooms, to ensure their preferences, choices, and rights are respected and upheld.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	27/10/2025
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Not Compliant	Orange	05/02/2026

Regulation 13(1)(b)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the religious and cultural needs of the resident concerned are, in so far as is reasonably practicable, met.	Not Compliant	Orange	05/02/2026
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	30/03/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/10/2025
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	30/03/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	27/10/2025

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	30/03/2026
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	05/01/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Orange	12/01/2026
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is	Not Compliant	Orange	18/03/2026

	implemented in the designated centre, as required.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	12/11/2025
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	12/11/2025
Regulation 31(2)	The person in charge shall ensure that, when the cause of an unexpected death has been established, the Chief Inspector is informed of that cause in writing.	Not Compliant	Orange	02/01/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on	Not Compliant	Orange	27/10/2025

	foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Not Compliant	Orange	27/10/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	15/01/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment	Not Compliant	Orange	15/01/2026

	referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/01/2026
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	15/01/2026
Regulation 8(1)	The registered provider shall take all reasonable	Not Compliant	Orange	27/10/2025

	measures to protect residents from abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	22/01/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/11/2025
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	30/11/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	30/11/2025