Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Sonas Nursing Home Innis Ree
Name of provider:	Sonas Nursing Homes Management Co. Limited
Address of centre:	Ballyleague, Lanesborough, Roscommon
Type of inspection:	Unannounced
Date of inspection:	04 December 2025
Centre ID:	OSV-0000350
Fieldwork ID:	MON-0049049

About the designated centre

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

Sonas nursing home Innis Ree, is a purpose-built centre for older people that accommodates 58 residents. It is located in the village of Ballyleague, approximately 14 km from the town of Roscommon and Longford and overlooks the river Shannon. The centre provides care for male and female residents requiring long-term, respite, convalescent and dementia care. The ethos of the centre, as described in the Statement of Purpose, is one of resident-centredness, and the motto is "We work in your home". Residents' accommodation is provided on the ground floor and comprises five separate communal areas, each with dining facilities reflecting a household model. There are 54 single-occupancy bedrooms and two twin-occupancy bedrooms, all with en-suite shower and toilet facilities. Bedrooms are spacious and have good storage, and each room has a kitchenette with a fridge, worktop and cupboards, a kettle, and a washing machine. The building makes good use of natural light, and en-suites were suitably ventilated. There are ample corridors for residents to walk, and the centre has landscaped gardens surrounding it and an enclosed courtyard garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	58

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
Thursday 4 December 2025	09:00hrs to 17:15hrs	Michael Dunne	Lead

What residents told us and what inspectors observed

On the day of inspection, the inspector observed that residents were supported to enjoy their lived environment supported by a team of staff who were kind, caring, and responsive to their needs. The overall feedback from residents was that the centre was a nice place to live and that staff were friendly and supportive. Residents who shared their views with the inspector said they liked living in the centre, and that this was their home. Residents were observed to be relaxed in the company of staff, although one resident told the inspector that sometimes there was not enough of staff available, and that sometimes they had to go looking for them. Although some actions were needed to bring the premises into compliance with the regulations, the centre environment appeared welcoming well-maintained.

This unannounced inspection was carried out over one day. Upon arrival, the inspector commenced a walkabout of the designated centre where they had the opportunity to meet and chat with residents, and staff as they began their day.

Some residents were observed remaining in their bedrooms after having their breakfast served to them. Several residents were observed being supported by staff with their personal care in a supportive and respectful manner. A small number of residents who presented with reduced mobility were observed been supported by staff to the day rooms, toilet facilities or back to their own rooms.

Following the centre walkabout the inspector held an introductory meeting with the person in charge, to discuss the format of the inspection, and to request records, and documents required for the inspection. The inspector also discussed with the person in charge the findings from the walk around, which included a number of concerns in relation to cleaning, the storage of equipment used to transfer residents and the systems in place to record that cleaning had occurred.

There were 58 residents living in the centre on the day of inspection. Residents' accommodation was arranged in single and twin bedrooms, which were located within four areas of the centre. Bedrooms were spacious, and well-equipped to promote independence; rooms contained small refrigerators, and washing machines for residents to maintain their personal laundry should they wish to do so. Large items of linen, and bedding were laundered off site. All bedrooms had access to their own en-suite, and shower facilities. Residents' bedrooms were found to be personalised with residents displaying their photographs, and momentos from home. Residents who spoke with the inspector said that they found their rooms comfortable, and that they had enough storage for their personal belongings.

The provider was found to have installed a new system for heating the designated centre, and feedback from residents was that they were happy, and content with the quality of heating in the centre.

A range of directional signage was located throughout the home to direct residents to key locations such as the day rooms, reception area or oratory. Notice boards located in the main foyer area provided information of local events, services, advocacy, and complaints. A schedule of activities was located in this area, but the range of activities available for residents to engage in appeared reduced due to the unavailability of permanent staff to provide social care activities support. Activities were provided on a five-day basis, and no staff were allocated on the roster to provide social care support over the weekends.

Activities available on the day consisted of one-to one support for residents, while a Mass service was scheduled for late morning. A bingo session was arranged post lunch, which appeared to be well-attended by the residents. Some residents said that they preferred to follow their own routines and spend their time quietly, either watching television or reading in their bedroom.

Residents told the inspector that they felt safe in the centre, and that they could talk to staff if they had any concerns. Residents who spoke with the inspector confirmed that they knew how to make a complaint, and were aware of advocacy services they could access if needed.

Residents were supported to have their meals in the location of their choice. There were four dining areas located within a homestead-style space, which also incorporated a day room. The meals available on the day of the inspection consisted of savoury mince or a boiled bacon meal.

The next two sections of this report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance judgements are set out under each regulation.

Capacity and capability

Overall, this centre was managed to ensure that safe, appropriate care, and support services were provided for the residents. However, significant focus and effort were now required to ensure that vacancies across all departments were filled. In particular, clinical staff, household, health care assistants, and staff supporting the provision of social care were filled to restore staffing levels in line with the provider's statement of purpose. These vacancies significantly depleted the provider’s ability to deliver a consistent service, and consequently, it negatively impacted on the oversight of care, and the compliance levels of some regulations.

This was an unannounced inspection carried out by an inspector of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspector also followed up on the previous compliance plans submitted by the provider, and found that the provider had implemented several measures to improve overall compliance, such as

the replacement of flooring and the provision of additional storage space in shared bathroom facilities. A number of additional commitments, such as the installation of clinical hand-wash sinks were planned in line with the dates submitted for the previous compliance plan. The provider had also completed a review of quality and safety for 2024, which incorporated residents' feedback, and this document also identified a programme of improvements for 2026.

The registered provider is Sonas Nursing Homes Management Company Limited. The provider is a national provider with a number of nursing homes in Ireland. The inspection was facilitated by the person in charge, and the assistant director of nursing. The provider has a senior management team working at the group level, including regional managers. The regional manager covering the Roscommon area supported the person in charge during the feedback session of the inspection.

The inspector found that the staff roster was not well-managed to ensure that they were sufficient staff resources allocated across the service. The clinical management team at the centre consists of the person in charge, the assistant director of nursing, and two clinical nurse managers (CNM). A review of rosters covering the period 24 November to 7 December 2025 found that both CNMs were routinely rostered to work as staff nurses. This impacted on their ability to provide sufficient oversight of the service and the supervision of staff. The number of staff nurses available on the roster was insufficient to cover staff's planned and unplanned absences. In spite of the difficulties posed by these staffing levels, the management team worked well together, but it was clear that the lack of permanent staff, and appropriate staff cover across the service was impacting on the quality of the service provided to residents.

In addition, to the low numbers of clinical staff, the whole time equivalent (WTE) numbers of care assistant staff were not in line with the numbers of staff indicated on the statement of purpose (SOP) dated 16 September 2025, and this also impacted on the ability of the provider to cover the roster. On three occasions from 24 November 2025 to 27 November 2025, the number of care assistant hours allocated to cover the roster did not meet the required level. On the day of the inspection, the inspector found that the provider had engaged agency staff to cover the shortfall in care assistant hours.

The inspector also found that the staff resources allocated to maintain the cleanliness of the centre had also been rostered to provide care to residents on the day of the inspection, and on two other occasions. This meant that there was no cleaner available in the centre until after 2 pm on these occasions. The impact of the lack of cleaning resources is described in more detail under Regulation 27: Infection control.

There were insufficient numbers of staff available on the roster to provide ongoing social care support to the residents. A vacancy on the roster since February 2025 had not been filled, and interim arrangements to mitigate the lack of activity support for residents covered Monday to Friday only. The inspector was informed that care

assistants were allocated to provide this support over the weekend; however, the roster provided for review did not evidence that this support was available.

The systems in place to ensure that relevant policies and record management oversight were effective, were not sufficient, as described under Regulation 21: Records. This had the potential to impact on service delivery as up-to-date information may not always be available to the local management team for review or decision making.

On the whole, the person in charge submits information to comply with Regulation 31: Notification of incidents; however, upon review, there was a failure to submit a written report to the Chief Inspector of Social services for Quarter 3 of 2025. This was a breach of this regulation, and meant that relevant information was not made available to the regulator within the required time period.

Records of complaints were maintained in the centre, there had been no complaints received since the last inspection in May 2025. However, the complaints policy updated on 16 September 2025, did not identify key personnel required to investigate a complaint or those with the responsibility to review the outcome of an investigation. The provider also maintained a log of compliments received from families, records indicated that 11 compliments had been received since the last inspection regarding the support provided to their relatives.

Regulation 15: Staffing

The registered provider did not 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. This was evidenced by:

- There was a failure to maintain staffing levels across key departments delivering the service, including clinical, care, household, and social care support.
- Some vacant shifts identified on the roster made available for review were not covered, and are discussed in more detail under Regulation 23: Governance and management.
- The number of staff available to deliver the service on the roster was not consistent with the numbers of staff identified on the Statement of purpose (SOP) dated 19 September 2025.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to regular training, and refresher training to ensure their mandatory training was up to date. All staff were up to date with their moving and handling, and safeguarding training. Two staff required refresher training in Fire safety, and this was already scheduled by the provider. Records showed that staff had access to infection prevention and control training.

Access to supplementary training such as medication management, wound care, and pain management was accessed on the provider's training platform, on the HSE-land training platform or, through training arranged in-house by the provider.

Judgment: Compliant

Regulation 21: Records

Some records made available for the inspector to review were not well-maintained. For example:

- Records relating to the cleaning of equipment used for the transfer, and mobility of residents were not well-maintained.
- Records made available to confirm staff attendance at pain management, and wound training were not complete.
- There were a number of gaps found in the progress notes recording residents' participation in activities. One care record found, there had been no engagement in activities records maintained from 10 October 2025 to 29 November 2025.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to ensure the service had sufficient staffing resources, and therefore, the management structure in place was not clearly defined with clear lines of accountability, and responsibility, in line with the centre's statement of purpose. For example:

- The provider had reduced the WTE (whole-time equivalents) of clinical nurse manager's hours, which impacted on their ability to provide ongoing support and supervision of the nursing and care teams. Clinical nurse managers were routinely used to cover nursing staff absences due to the lack of nurses available in the centre.

There was a failure to maintain staffing levels across several departments delivering the service. For example:

- The number of staff nurses available on the roster had reduced from 11 to 8. This effectively meant that there were insufficient numbers of staff to provide cover for staff absences, annual leave, and staff training.
- There was a deficit in the hours available to maintain the cleanliness of the designated centre. There was no cleaner available in the centre until the afternoon on the day of the inspection.
- A staff member was rostered to cover a care role and a housekeeping role on the same day, and on two other occasions.
- The position of the part-time activity worker had been vacant since February 2025. Interim arrangements in place to mitigate the lack of activity support for residents, did not provide sufficient resources to cover the activity schedule seven days a week.
- A review of the rosters made available to review confirmed that there was a deficit of care assistant hours available to provide support to the residents on four occasions in line with the providers' allocated hours.

The management systems in place to monitor the quality of the service provided were sufficient and did not ensure that the services provided are safe, appropriate, and consistent. Consequently, there were inadequate systems in place to identify, manage and respond to risk. This was evidenced by;

- A review of the risk register found that there was no assessment in place to mitigate against the risks associated with the lack of staffing.
- Oversight systems failed to identify that some residents' activity care plans were not being implemented.

The registered provider had not ensured effective governance, and oversight arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control measures. This was evidenced by the following findings;

- There was a lack of staffing resources on the day of the inspection to ensure that the environment was cleaned.
- There was no effective system and oversight in place to ensure that equipment was cleaned in between resident use.
- Oversight of staff required an improvement as cleaning records were not maintained or reviewed by senior personnel.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose (SOP) in place, which included the information set out in Schedule 1 of the regulations. However, this document

required a number of amendments to accurately reflect the current service, for example:

A more transparent and accurate representation of the number of whole-time equivalents (WTE) for staff working across most departments in the designated centre. There were several discrepancies found between the numbers of staff available, and their working hours identified in the Statement of purpose dated 16 September 2025, and in the Statement of purpose submitted to vary the registration dated 17 June 2024.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all accidents, and incidents involving residents was maintained in the centre. However, the person in charge did not provide a written report to the Chief Inspector of Social services at the end of the third quarter 2025, in relation to the occurrence of an incidents in relation to any occasion when restrictive practices was used.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy advertised in the designated centre. However, the version on display at the time of the inspection did not identify the person allocated to carry out an investigation, nor did it identify the person allocated to carry out a review of an investigation.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider did not ensure that all policies were in place to meet the requirements of Schedule 5, for example:

- A number of Schedule 5 policies made available for the inspector to review were out of date. The person in charge later confirmed that these policies had been updated, but had not been included on the list of Schedule 5 policies for review.
- A written visitor policy had not been developed at the time of this inspection.

- The complaints policy was not in line with S.I. No 628/2022 and did not identify complete arrangements for the complaints procedure.
- Updated Policies were not always available to staff, as a number of policies made available for review were out of date.

Judgment: Substantially compliant

Quality and safety

On balance, residents living in this centre received a good standard of care on a day-to-day basis. There was a risk that inconsistent staffing levels could impact on these standards and this is discussed throughout this report. However, more focus was required to ensure that residents' rights, infection control, and care planning were in line with the provider's statement of purpose.

The inspector reviewed a sample of residents' care files, and found there was evidence that the residents' needs were being assessed using validated nursing tools. Assessments included the risk of falls, malnutrition, assessment of cognition, and dependency levels. However, the inspector also found that care plans relating to social care support required strengthening to ensure each resident's care plan reflected their assessed needs, and interventions required to meet those needs were in place. For the most part, progress notes identifying daily interventions were reflective of health care and clinical interventions, while there was limited detail highlighting how residents were engaging in social care.

Overall, care plans were well-developed for residents' presenting with communication needs or for residents presenting with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Staff were observed supporting residents in a person-centred manner, and it was clear that they were aware of key triggers that may impact on the residents' behaviours. This knowledge helped to create a calm atmosphere, where residents could enjoy their lived space. Residents who had difficulty expressing their views were given time, and space to make their views known.

The general practitioners (GP) attended the centre on a regular basis, or more often if residents required review. Residents also had timely access to health and social care services, and specialist input from psychiatry of old age if required. There was good knowledge among the staff team of residents health care needs, and records confirmed that where treatment advice was received, that this was updated in the residents' care records.

There was limited support made available for residents to participate in activities. The inspector observed that residents' participation, and enjoyment in the activities provided was not accurately monitored to ensure that residents were provided with

activities in accordance with their interests or capacities. The inspector saw that the schedule of activities on the day of the inspection consisted of one-to-one support from 10am to 11:30am with mass scheduled for 11:30am, and a Bingo session scheduled for the afternoon. Furthermore recording and oversight of one-to-one activity provision for those residents who did not engage with the daily planned activity provision was not well-documented, and as a result, the provider could not be assured that these residents were provided with meaningful occupation in line with their capacity, and preferences.

The provider had made a number of improvements to the premises, which included the installation of a new heating system. This greatly improved residents' comfort, and maintained a suitable temperature in the centre. Some areas of the centre appeared tired, and in need of renewal. Carpets covering some communal areas of the centre were stained, while some doors, and door jambs were scuffed and damaged. The provider informed the inspector that there were arrangements in place to address these issues, and that they formed part of the improvement plan for 2026.

The oversight of infection prevention and control appeared to have disimproved since the last inspection. Records confirming that equipment had been cleaned in between resident use were not well-maintained with inadequate levels of oversight, and sign-off by senior management. There was inconsistent resources allocated to cleaning of the premises, which appeared to have contributed to this deterioration.

Regulation 10: Communication difficulties

A review of records for a resident with impaired vision found that the registered provider had ensured that this resident was supported to communicate freely in line with their assessed needs. A care plan was in place, which set out the specific support needs, and relevant interventions to support their communication requirements.

Judgment: Compliant

Regulation 11: Visits

The inspector found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished. Visitors were observed attending the centre throughout the day, and meeting with their relatives.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had access to, and were supported to maintain their own personal clothing and possessions. There was sufficient storage space located in all residents' bedrooms, which included a lockable unit for the secure storage of personal items. Laundering of residents' personal clothing was carried out by an external laundering service that delivered clean laundry to the centre twice a week. Improvements were noted in shared bathroom facilities, with residents now allocated individual storage facilities.

Judgment: Compliant

Regulation 17: Premises

The provider had not ensured that all parts of the premises were appropriate to the number and needs of residents and in accordance with the centre's statement of purpose. For example:

- The flooring on one corridor was stained.
- Residents' bedroom doors were damaged, and scuffed.
- Signage on some utility doors were missing which meant the contents of the store may not be known.

Judgment: Substantially compliant

Regulation 26: Risk management

There is a risk policy, and procedure in place that contained all of the requirements set out under regulation. The local risk register was comprehensive, and detailed. For the most part, risks were kept under review by the person in charge; however, the inspector identified a number of unmitigated risks during the inspection, and these are discussed in more detail under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 27: Infection control

The environment, and equipment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by;

- The inspector observed inadequate storage practices as the equipment for residents, was found stored in an area assigned to receive clean laundry from an external provider. This posed a risk of cross contamination.
- Equipment used for the transfer of residents including a full body hoist, a standing hoist, and a transfer aid (sara stedy) were visibly unclean.
- Poor cleaning, and disinfecting processes were found, bed pans, and commode chairs located in the sluice facility were unclean.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of resident care records, found inconsistencies in the assessment and implementation of some residents care plans. For example:

- There was no social care assessment in place for one resident, although there had been a care plan developed. These arrangements cannot ensure that the care plan was correctly prepared based on the resident's needs, preferences, and wishes.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There were insufficient resources made available to ensure that residents had opportunities to participate in activities in accordance with their interests, and capacities. For example,

- Activities were scheduled on a five day basis as opposed to a seven day schedule of activities. There was no staff allocated on the roster to provide activities over the weekend. These arrangements did not assure that a continual service was provided to the residents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sonas Nursing Home Innis Ree OSV-0000350

Inspection ID: MON-0049049

Date of inspection: 04/12/2025

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
Outline how you are going to come into compliance with Regulation 15: Staffing: Monthly HR Meetings are held to review the staffing requirements. In addition, a weekly tracker is submitted to the recruitment department to action and support through advertisement and recruiting of staff. Following the inspection, a further review was conducted. The planned roster is determined as per resident dependency and occupancy. Since the Inspection 3 x Full Time HCA's were recruited and 2 x HCA's have returned from unplanned long-term leave. A full-time cleaner has also been recruited in addition to a chef and part-time kitchen assistant. Our HR Department are currently processing overseas HCA Staff. Whilst we return to our full complement we are rostering agency staff and we aim to roster the same agency staff so that we can maintain continuity of care.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: An enhanced record for the cleaning and decontamination of equipment is now in place. This is reviewed by the management team on a daily basis and on their walkarounds. All Mandatory training records are in place and pain control and wound management training is recorded for appropriate staff. The training matrix is fully up-to-date. Weekly review of the residents' recreational needs being met is taking place and the PIC and Quality Manager (QM) review the records relating to same on a weekly basis.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The clinical nurse managers management hours have been reviewed and the CNM has protected management hours.

Skill mix is continuously reviewed by the PIC and prior to issuing the next roster it is reviewed by the QM as evidenced during the inspection when there are shortages then measures are put in place to reduce/eliminate risks, such as the application of agency staff.

We have an enhanced recruitment drive in place in order to try and recruit to the recreational therapy team. Additional activities by external providers are being provided.

We did not need 11 nurses to run the service – we were over supplied at that time. We now have 9 nurses employed plus 2 x CNMs and 1 x APIC. We are able to maintain management hours with this compliment and facilitate annual leave and training.

Full time cleaning hours are now restored.

Since the inspection we have not needed to roster a staff member for multiple roles on the same day and we will ensure that this does not happen again.

We have recruited a second part time activities/recreational therapy person 2 days per week and we are continuing to recruit for another Recreational Therapist in the interim we have employed agency to cover HCA shifts and assigned HCA staff to activities. We have also booked external people to provide various entertainment, such as musicians and exercise to music therapy every Wednesday. Our full-time physiotherapist also provides therapy activities twice a week.

The HCA roster has not been short of the required hours due to the application of agency staff.

The live risk register has been updated to reflect the current staffing situation and this has been escalated to the provider.

A full review of the residents' activity care plans is underway and all will be completed by 31st March 2026.

The centre has been deep cleaned.

The QM has oversight of the cleaning schedules and also checks the cleanliness of the residents' equipment on their walkarounds.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
A revised statement of purpose will be submitted to the Chief Inspector as part of this compliance plan.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A retrospective notification was submitted on the 26th. October 2025 following the inspection. Going forward the Quality Manager will ensure that the PIC has submitted all of the required information.

Regulation 34: Complaints procedure	Substantially Compliant

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

The displayed complaints posters have been updated.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
On the day of inspection, the Person in Charge did not present the most up-to-date policies that are stored electronically. A small number of the paper versions had not been

updated. All Schedule 5 policies are up-to-date. All policies are live and saved on the Dropbox folder which all staff have access to at all times. The QM has discussed this with the PIC to ensure compliance.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Carpet cleaning for the corridors will be arranged to remove any staining. The full replacement of all corridor carpets is part of our overall capital expenditure plan for the facility alongside the remaining 12 bedrooms that are our priority. All doors, skirtings and architrave have been painted. Painting and touch ups of scuff marks and general damage is ongoing and continuous. Appropriate doors signs identifying store room contents and use will be put in place by the 30th April 2026.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Storage rooms were all reviewed following the inspection. Staff have been spoken to at the daily Safety huddles to remind them to store items and equipment appropriately. This is being monitored on the management walkarounds. An enhanced system and record keeping is now in place for the decontamination of resident moving and handling equipment enabling staff to document the specific item cleaned. Staff have been met with regarding the requirement to appropriately disinfect resident equipment. All sluice rooms have been deep cleaned.

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

All social assessments have been reviewed and are now up-to-date. We use 'All About

Me’ and a psycho-social screening assessment for every resident.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: We have recruited a second part time activities/recreational therapy person 2 days per week and in the interim, we have employed agency to cover HCA shifts and assigned HCA staff to activities. We are continuing to recruit further to this role. We have also booked external people to provide various entertainment such as musicians and exercise to music therapy every Wednesday. Our full-time physiotherapist also provides physical therapy group activities twice a week.	

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	31/05/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2026
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	Substantially Compliant	Yellow	18/03/2026

	and are available for inspection by the Chief Inspector.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/05/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/05/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the	Substantially Compliant	Yellow	18/03/2026

	standards published by the Authority are in place and are implemented by staff.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/03/2026
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.	Not Compliant	Orange	26/10/2026
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Substantially Compliant	Yellow	18/03/2026
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred	Substantially Compliant	Yellow	18/03/2026

	to at paragraph (c).			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	18/03/2026
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	18/03/2026
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	18/03/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	18/03/2026
Regulation 9(2)(b)	The registered provider shall provide for residents	Substantially Compliant	Yellow	31/03/2026

	opportunities to participate in activities in accordance with their interests and capacities.			