



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

## Issued by the Chief Inspector

Name of designated centre:	Maryfield Nursing Home
Name of provider:	West of Ireland Alzheimer Foundation
Address of centre:	Farnablake East, Athenry, Galway
Type of inspection:	Unannounced
Date of inspection:	11 February 2026
Centre ID:	OSV-0000359
Fieldwork ID:	MON-0049630

## About the designated centre

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

Maryfield Nursing Home is a designated centre that provides long term and respite care for 23 male or female residents who have dementia or a related condition. The centre is located in a rural setting approximately two kilometres from the town of Athenry and 25 kilometres from Galway city. The centre is purpose built. It is single storey and residents' accommodation is provided in 11 single and six double rooms. There is adequate sitting and dining space to accommodate all residents in comfort. A safe garden area is also available. The environment has been enhanced by the use of dementia friendly features that include signage, good levels of natural lighting and a homelike layout.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	23
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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
Wednesday 11 February 2026	09:20hrs to 17:00hrs	Sean Ryan	Lead

## What residents told us and what inspectors observed

Residents living in Maryfield Nursing Home were observed to receive individualised, person-centred care and support from a consistent team of staff who demonstrated a good understanding of their assessed needs, preferences and daily routines. The service predominantly supported individuals with cognitive impairments and memory-related conditions, and care practices reflected an awareness of the additional supports required to promote meaningful engagement. Throughout the inspection, residents were observed to receive a good standard of care and were supported to remain socially engaged, in accordance with their abilities and interests.

The inspector arrived at the centre unannounced and was met by the Person in Charge. An initial walk-through of the premises was completed, during which the inspector met with residents and staff members. While all residents were greeted during the visit, four residents were spoken with in more detail regarding their lived experience in the centre. Residents appeared comfortable and relaxed within their surroundings.

The overall atmosphere was warm and inviting. Residents were seen spending time in their bedrooms, visiting one another, and engaging in activities such as listening to music. A small number of residents were observed participating in baking activities, while others were supported with one-to-one engagement based on their preferences. Some residents chose to rest in communal areas, observing the activity around them in a calm and content manner. These observations indicated that residents were afforded choice in how they spent their day.

Staff were attentive and responsive to residents' needs and demonstrated familiarity with their individual care and communication requirements. Interactions reflected an understanding of supportive communication approaches, including the use of clear, simple language, gentle prompting, appropriate reassurance and respectful pacing of conversations.

The inspector observed the mealtime experience during both morning and afternoon dining periods. Meals were served in a communal dining room, where residents were encouraged to sit together to support social interaction. Staff remained present throughout, and assisted residents, where required and engaged them in conversation to enhance the social aspect of dining. Meals were attractively presented. However, it was observed that residents were not offered a choice of meal, as all residents received the same option.

The provider had completed some improvement works to the premises since the previous inspection. A number of bedrooms had been repainted, and some internal doors had also been refreshed. Some previously identified issues had been addressed. The external garden area had been tidied, creating a more pleasant and

accessible outdoor space for residents to enjoy. However, some areas of the premises were not appropriately maintained. These included broken taps in communal toilet facilities, one toilet that was out of order, and sections of damaged flooring, including in the sluice room.

Improvements were noted in the management of some storage areas in the centre. Linen trolleys were not stored along corridors, which supported residents to move freely and safely through the corridors unobstructed. However, continence wear products were observed stored on open shelves along a corridor and also on top of a hand-towel dispenser in a communal toilet.

A number of fire safety concerns were observed. Some fire doors were not closing fully and others had visible gaps which could compromise fire containment. In addition, some gaps were observed where service pipes penetrated walls which could pose a risk that fire and smoke would not be effectively contained.

Throughout the day, most residents were observed participating in a range of activities, including music sessions, arts and crafts, baking, and general social interaction. Others were seen enjoying their own company in a calm and relaxed manner. One resident was seated comfortably with a table positioned in front of them, displaying personal photographs and memorabilia. This reflected an individualised person-centred approach to care.

Information boards within the centre displayed details of services available to residents, including safeguarding supports, pharmacy services, and access to independent advocacy services. Mass was celebrated in the centre on a regular basis.

The following sections of this report detail the findings with regard to the capacity and capability of the provider and how this supports the quality and safety of the service provided to residents.

## Capacity and capability

This was an unannounced risk 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 (as amended). The inspector also followed up on the action taken by the provider to address issues identified during the previous inspection of the centre in April 2025. In addition, unsolicited information received by the office of Chief Inspector was reviewed, and was not substantiated on this inspection.

The findings of this inspection were that the centre had an effective management structure that was responsible and accountable for the provision of safe and quality care to the residents. Following the previous inspection, the provider had taken

some action to improve the quality of the premises, to ensure it met the individual and collective needs of the residents, and to ensure care plans were reflective of residents current care needs. However, this inspection found that there were aspects of the management systems that were not fully effective to ensure appropriate oversight of the premises and fire safety. In addition, residents individual assessment and care plans and nutritional care were found not to be in full compliance with the regulations.

West of Ireland Alzheimer Foundation is the registered provider of Maryfield Nursing Home. It is a company comprised of eight directors, one of whom represented the registered provider. Another director was a regional manager and a person participating in the management of the centre, and provided governance and support to the person in charge. Within the centre, the management structure was unchanged since the previous inspection. The nurse management structure consisted of a person in charge, who was supported clinically and administratively by an assistant director of nursing, who worked part-time.

The provider had management systems in place to monitor, evaluate and improve the quality and safety of the service provided to residents. A schedule of clinical and environmental audits were in place for 2026 to monitor key aspects of the service. This included audits of infection prevention and control, medication management, restrictive practices, nutrition, incidents and falls, and records. A sample of completed audits were reviewed and were found to be effective to support the management team to identify some risks and deficits in the service. Where areas for quality improvement were identified, the actions were recorded on a quality improvement plan and assigned to personnel in their relevant departments. However, associated action plans were not always communicated to staff or implemented in a timely manner. For example, a nutritional audit completed in early January identified deficits in the residents dining experience and outlined specific actions required to address these issues. However, these actions had not been communicated to relevant staff or implemented at the time of this inspection.

There were systems in place to monitor and respond to risks that may impact on the safety and welfare of residents. The risk management systems were informed by an up-to-date risk management policy. A review of the risk register evidenced that clinical and environmental risks were assessed and reviewed at frequent intervals. However, while risks were identified and escalated to the provider and senior management team, timely action was not always taken to mitigate them. Some risks in relation to the premises remained outstanding for a significant period of time without clear time-frames for when appropriate control measures would be implemented. In addition, not all known risks within the centre had been formally assessed and recorded in the risk register. While senior management were aware of specific fire safety risks, these had not yet been effectively communicated to staff within the centre. Consequently, staff did not have sufficient awareness of these risks to inform appropriate prevention and control measures.

A record of all accidents and incidents involving residents that occurred in the centre was maintained. Records reviewed evidenced that there were effective systems in place to record, investigate and learn from adverse incidents. Notifiable incidents

were submitted to the Chief Inspector within the time frame specified under the regulations.

Record management systems comprised of a paper-based system. A review of staffing records found that all staff personnel files contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. Records were securely stored and appropriately maintained.

There were sufficient numbers of suitably qualified staff available to support residents' assessed needs. Staff had the required skills, competencies, and experience to fulfil their roles. The team providing direct care to residents consisted of registered nurses and a team of health care assistants. Communal areas were appropriately supervised, and the inspector observed kind and person-centred interactions between staff and residents.

There was a comprehensive training and development programme in place for all grades of staff. Staff demonstrated an appropriate awareness of their training with regard to fire safety procedures, and their role and responsibility in recognising and responding to allegations of abuse. There were systems in place to induct, orientate, support and supervise staff through senior management presence.

### Regulation 15: Staffing

The number and skill-mix of staff was appropriate with regard to the needs of the residents, and the size and layout of the designated centre.

Judgment: Compliant

### Regulation 16: Training and staff development

Staff were facilitated to attend training relevant to their role and responsibilities.

All staff had completed additional, role specific, training to provide them with the necessary knowledge and skills to effectively support residents with symptoms of dementia.

Staff were also appropriately supervised, with regular supervision in place to support their professional development and to ensure the delivery of safe and quality care to residents.

Judgment: Compliant

## Regulation 21: Records

The registered provider ensured that the records set out in Schedules 2, 3 and 4 of the regulations were safely stored in the designated centre and were available for inspection.

Judgment: Compliant

## Regulation 23: Governance and management

The management systems in place to monitor the quality of the service were not fully effective to ensure the service provided to residents was safe and effectively monitored. For example;

- Communication systems were not fully effective in ensuring that information was shared at all levels of the organisation. Audit findings and associated action plans were not consistently communicated to staff to support implementation of required improvement. In addition, relevant risk information, held at provider level, was not shared with the local management team in a timely manner.
- Scheduled audits of fire safety did not identify areas of the service that required quality improvement such as the impaired integrity of fire doors.
- The system in place to record and manage risk did not consistently ensure that identified risks were addressed in a timely manner. Where risks were escalated to the provider, there was limited evidence of timely action or defined time-frames for resolution. This includes deficits and risks in relation to the maintenance of the premises that had been escalated to the provider for further action.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

Notifiable events, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services, within the required time-frames.

Judgment: Compliant

## Quality and safety

Residents living in the centre were supported in a manner that promoted their safety and overall well-being to ensure they could enjoy a good quality of life. While action had been taken to improve the quality of care plan documentation, care plans did not consistently reflect residents' current needs, nor did they identify changes in their condition. In addition, arrangements in relation to nutrition did not always ensure that residents received food in line with their assessed nutritional requirements or were consistently supported to exercise choice in relation to their meal preferences. Additionally, fire safety arrangements, including the containment and management of fire did not ensure that residents were fully protected from the risk of fire.

The inspector found that the needs of residents were known to the nursing and care staff. A sample of residents' individual assessment and care plans were reviewed. While there was evidence that residents needs had been assessed using validated assessment tools, and all residents had a care plan, care plans were not always reflective of residents actual care needs or updated following a change in their needs. Consequently, care plans did not always contain person-centred guidance on the current care needs of the residents.

Residents were provided with access to appropriate medical care, with residents' general practitioners providing on-site reviews. Residents were also provided with access to other health care professionals, in line with their assessed needs.

A review of food and nutrition found that arrangements were in place for residents to access the expertise of health care professionals such as dietetic services, and speech and language therapists for further expert assessment. Residents were provided with access to adequate quantities of food and drinks, and meals were prepared, cooked and served on-site. However, this inspection found that residents were not consistently offered choice at mealtimes and, although the food provided was wholesome and nutritious, it did not always align with residents' assessed dietary requirements.

There were arrangements in place to safeguard and protect residents from the risk of abuse. A safeguarding policy detailed the roles and responsibilities of staff, and the appropriate steps to take, should a concern arise. All staff spoken with were clear about their role in protecting residents from abuse.

The inspector reviewed the arrangements in place in relation to fire safety. Regular fire safety checks in the centre were completed and recorded. There were daily, weekly and monthly checklists which included testing of fire equipment, fire alarm testing, emergency lighting, means of escape and fire exit doors, all of which were up-to-date. However, this inspection identified a number of deficits which could impact the containment of fire within the premises. Significant gaps were observed between the bottom of some fire doors and the floor, and penetrations through walls and ceilings were not adequately sealed. This could potentially impact on fire containment measures in the event of a fire. The provider had proactively commissioned a fire safety risk assessment of the centre in December 2025, which

identified a substantial number of risks that required remedial action. On the day of inspection, action was being taken to appoint a competent person to complete the necessary works in order to effectively manage and mitigate the identified risks.

Some action had been taken with regard to the maintenance of the premises since the previous inspection. Redecoration works had been completed in some areas that included some bedrooms, communal areas such as the dining room, and corridors. However, remedial works to address issues previously identified with some door closure devices, damaged flooring and doors had not been completed. In addition, premises-related issues identified by the management team, such as a leaking section of the roof, and the requirement for external tree maintenance had been escalated to the provider in 2025, but had not yet been addressed at the time of this inspection.

There was a programme of activities available in the centre and residents appeared to enjoy music, chats, and individual activities with an activities co-ordinator. Residents told the inspector that they were satisfied with the activities on offer and enjoyed the social aspect of group activities.

### Regulation 17: Premises

There were areas of the premises that did not meet the requirements of Schedule 6 of the regulations. For example;

- Floor coverings in some areas were not appropriately maintained. For example, the floor covering in the sluice room was visibly damaged and the concrete floor exposed.
- Taps in two communal toilets were broken and not functioning and a communal toilet in another area of the centre was out of order. This reduced the number of toilets available to residents, in close proximity to their bedrooms.

Judgment: Substantially compliant

### Regulation 18: Food and nutrition

Food and nutrition was not always delivered in line with the regulatory requirements. For example;

- Residents' dietary needs were not consistently met, as prescribed by allied health care professionals. A number of residents who were prescribed a therapeutic diet and fortified meals to manage their weight were not provided with their prescribed diets.

- Residents were not offered a choice at mealtimes. All residents received the same meal, the menu was not displayed, and residents were not consulted regarding their meal preferences.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

The provider did not have adequate precautions against the risk of fire in place. For example;

- The storage room leading to the protected bedroom corridor area was filled with equipment and the doors were damaged, kept open, and could not close effectively. Electrical equipment in this room were also being charged.
- The external gates at the rear of the building outside the bedroom and dining room final exit corridor were locked with a chain and key operated lock. The fire assembly point was located to the front of the building, beyond the gates. This presented a potential risk to safe and timely evacuation in the event of a fire emergency.
- Records indicated that weekly fire door checks were being undertaken. However, these checks consistently recorded no defects, despite management being aware of certain fire doors that were compromised. Consequently, fire safety checks were not being effectively implemented to ensure fire risks were appropriately identified and managed.

Arrangements for the containment of fire was inadequate. For example;

- A number of fire doors were observed to be in a compromised condition. Deficits included excessive gaps, visible damage, and the absence or deterioration of required smoke seals. As a result, the integrity and effectiveness of these doors in event of a fire could be impaired.
- Other fire doors did not appear to meet the criteria of a fire door as they had domestic type locks and handles, screws missing from hinges and the hinge was not fire-rated.
- Services such as pipe-work and cabling, were observed passing through walls and ceilings without evidence of appropriate fire stopping. In addition, the provider's own fire risk assessment had identified a number of similar deficiencies, including fire stopping issues within the attic, roof space and boiler house.

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not guided by a comprehensive assessment of the residents care needs. For example, some resident's care plans did not accurately reflect the needs of the residents and did not identify appropriate interventions to protect residents when identified as being at high risk of falls or at risk of malnutrition.
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of a resident whose general condition had deteriorated had not been updated to reflect an increase in their care needs. Consequently, the care plan did not reflect the nursing and medical interventions required to support their needs.

Judgment: Substantially compliant

### Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre, as required or requested.

Services, including physiotherapy, tissue viability nursing expertise, speech and language, and dietetics were available through a system of referral.

Judgment: Compliant

### Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse.

Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

Judgment: Compliant

### Regulation 9: Residents' rights

Residents' rights were respected in the centre and the service placed an emphasis on ensuring residents had consistent access to a variety of activities, seven days a week. Residents who did not participate in group activities were provided with one-to-one time.

Residents had access to advocacy services and information regarding their rights, and were supported to engage in activities that aligned with their interests and capabilities.

Residents were supported to exercise their religious beliefs and were facilitated to attend religious services in the centre, if they wished.

Judgment: 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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for Maryfield Nursing Home OSV-0000359

Inspection ID: MON-0049630

Date of inspection: 11/02/2026

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

## Section 1

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

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> <li>• A review of how audit findings and risk information are communicated has been revised to ensure that any corrective actions required are implemented in a timely manner. This will include communication through handover meetings, staff meetings and management meetings with it being recorded in the minutes. A review of how and when information received by the provider is communicated to the local management team has been reviewed and communication will be immediate going forward.</li> <li>• A review by a fire consultant had been undertaken to identify fire risks. Training will be provided to management and maintenance staff on identification of fire risks and the importance of swift action to rectify any deficiencies identified. A review timetable of all fire doors will be implemented to ensure that they are checked on a regular basis to ensure that there are no deficiencies. Training provided to internal auditor will ensure that audits being undertaken are fully effective in identifying risks.</li> <li>• All remedial action required to rectify risks will have a timebound timeframe for rectification. Provider will look to sourcing alternative contractor solutions in instances where there is a delay in having risk issues addressed.</li> </ul>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <ul style="list-style-type: none"> <li>• The damaged floor covering in the sluice room is being replaced and the floor covering in the nurses' station is being repaired.</li> <li>• The taps in the communal toilets have been repaired.</li> </ul>	

- The third communal toilet has been repaired.

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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 menu has been revised to ensure that the dietary needs of all residents are met. The menu will be kept under constant review to ensure that any changes in residents dietary needs are accommodated in the menu on offer. A whiteboard in the kitchen details the assessed dietary needs of all residents and any changes are communicated by the nurse on duty to ensure that there is no delay in implementing changes.
- The new menu offers a choice at mealtimes with the choices displayed on a menu board with residents consulted in advance on their meal choice.

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Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- A fire safety assessment has been undertaken, and contractors have been engaged to rectify the identified shortcomings prioritising the red fire risks. A copy of the fire survey has been submitted to HIQA. Each risk has been assessed, and mitigating fire controls are in place to mitigate these risks until corrective works have been undertaken.
- The equipment, bedding, stationary and electrical equipment have been removed from the storeroom leading to the protected bedroom corridor. All staff have been made aware of the fire safety issues identified in the fire survey and the area is continually monitored both during the day and at night with 15-minute checks of impacted areas.
- A contractor has been engaged to ensure that the gates can be disengaged immediately in the event of an emergency. In the interim, the locks have been removed from both gates. The door at the end of the dining room allowing free access for residents to the garden area is now secured by a maglock (which is connected to the fire alarm system). However, it is monitored by staff and should residents wish to enter the garden area they will be accompanied in doing so.
- Training is being provided to ensure that fire door checks are effective.
- All bedroom doors are being replaced with remedial works to the remaining doors (replacement of hinges and locks) to ensure compliance with fire regulations. As above, all staff have been made aware of the fire safety risks identified in the fire survey and the impacted area is continually monitored both during the day and at night considering the increased risk. They are also aware of additional actions to be taken in the event of a

fire including the evacuation of all compartments. The management of fire risk and the mitigating factors in place / additional actions required will be included as an agenda item at all handover meetings until the rectification works have been completed.

- Works by a competent fire contractor are commencing on the 7th April to rectify the issues identified to ensure the integrity of the various compartments to ensure containment in event of fire. Again, staff have been made aware of the increased risks and the vigilance and checks necessary to mitigate these risks pending the issues being rectified. The major works to install a new Gypsum Horizontal Shaft Wall along the escape corridor of the protected bedroom section is also commencing on the 7th April.

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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:

- Internal training has been provided to ensure that care plans accurately reflect the care needs of the residents including any interventions necessary to protect residents when a risk has been identified. Oversight of this will also be included in care plan audits.
- The importance of reviewing and updating care plans when a resident's condition changes has been communicated to all nursing staff. This will also be part of care plan audits going forward.

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## Section 2:

### Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	17/04/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	12/03/2026
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional	Substantially Compliant	Yellow	12/03/2026

	assessment in accordance with the individual care plan of the resident concerned.			
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	17/04/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	24/04/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	24/04/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	24/04/2026
Regulation 28(2)(i)	The registered provider shall make adequate	Not Compliant	Orange	30/06/2026

	arrangements for detecting, containing and extinguishing fires.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	12/03/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	12/04/2026