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:	Nenagh Manor Nursing Home
Name of provider:	Foxberry Limited
Address of centre:	Yewston, Nenagh, Tipperary
Type of inspection:	Unannounced
Date of inspection:	16 February 2026
Centre ID:	OSV-0000422
Fieldwork ID:	MON-0049406

About the designated centre

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

Nenagh Manor nursing home is located a short walking distance of the town of Nenagh. It is set out over three levels and provides 24 hour nursing care. It can accommodate 50 residents over the age of 18 years and includes a dementia specific unit which accommodates 10 residents. It is a mixed gender facility catering from low dependency to maximum dependency needs. It provides short and long-term care, convalescence, respite and palliative care. There is a variety of communal day spaces provided including dining rooms, day rooms, conservatory, hairdressing room and residents have access to landscaped secure garden areas. Bedroom accommodation is offered in single and twin rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	47

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
Monday 16 February 2026	18:00hrs to 21:00hrs	Yvonne O'Loughlin	Lead
Tuesday 17 February 2026	07:15hrs to 15:15hrs	Yvonne O'Loughlin	Lead
Thursday 5 March 2026	07:30hrs to 13:30hrs	Yvonne O'Loughlin	Lead
Monday 16 February 2026	18:00hrs to 21:00hrs	Brid McGoldrick	Support
Tuesday 17 February 2026	07:15hrs to 15:15hrs	Brid McGoldrick	Support
Thursday 5 March 2026	07:30hrs to 13:30hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

An unannounced inspection of Nenagh Manor Nursing Home was carried out over three days, with day one starting on the evening of the 16 February 2026 as a focused Infection prevention and control inspection. Due to the findings on day one and day two, a day three inspection was carried out on the 5 March 2026.

As of the 16 February 2026, the centre had experienced three significant outbreaks of infection since October 2025. The most recent outbreak of norovirus affected 27 residents.This inspection found that prior to this outbreak, house keeping hours had been reduced, and following the outbreak, a deep clean of all areas of the centre had not been completed.

During a tour of the premises, inspectors observed areas of the centre that were not adequately clean. The findings in relation to cleanliness are discussed further in the report. The person in charge was responsive to issues identified during the first two days of the inspection. However, when the inspectors returned to the centre on the 5 March 2026, a further outbreak of infection was ongoing. Inspectors found that it was not being effectively managed, further details are out lined under Regulation 27: Infection control.

The inspectors spoke with many visitors and residents throughout this inspection and the overall feedback was that there was not enough staff to meet the needs of the residents. Visitors praised the staff for their kindness and most of the visitors said "staff were all doing their best but had no time to sit and chat as they were rushed off their feet". The staff working in the centre agreed with this. This is a repeat finding from the previous inspection of July 2025. On the evening of the first day of the inspection, the inspectors observed that some staff who required enhanced levels of supervision, were working unsupervised. Inspectors observed residents waiting for assistance with hygiene needs, and to be returned to bed whilst staff were busy attending to other residents. The dependencies of the residents were reviewed and found that 62 per cent of residents accommodated in the centre were high or maximum dependency which meant that some residents required the assistance of at least two people to attend to their assessed needs.

Inspectors attended two nursing handovers and found that the quality of the information shared was insufficient to provide a clear overview of the residents condition and care requirements. Key information was not communicated to the team. For example, that the centre was in an outbreak of infection.

Nenagh Manor Nursing home is a large period building close to Nenagh town. The centre catered for 50 residents which included a 10-bedded dementia focused care unit. The centre was set out over three floors, each floor was accessible by a lift or

stairs. Including the dementia unit, there were four separate care areas with the main hub being the nurses station on the 1st floor.

The fire alarm panel was located in the front reception area. The inspectors noted it to be free from faults, and was accompanied with fire evacuation floor plans that indicated compartments and fire exit routes.

Hand sanitisers were available in wall-mounted dispensers along the corridors and at the point of care for each resident. Some barriers to effective hand hygiene practices were observed during the course of this inspection. Clinical hand-wash sinks that complied with the recommended specifications were not available in all areas of the centre where residents were living. This meant that staff could not easily wash their hands if visibly soiled. This was a repeat finding from a previous inspection.

On the third day of the inspection, the inspectors returned to speak to some of the visitors that were met previously. One visitor said that the maintenance issue that she had been waiting for six months to address had been fixed promptly, nonetheless, the overall view from the visitors spoken with remained that more staff were needed.

The inspectors observed two sittings of resident mealtimes. Residents and families said they were happy with quality of the food served. Residents enjoyed a cup of tea mid-morning in the day area. Some residents had no side table to rest their cup and saucer so it was left by their feet. This meant that residents did not have easy access to more tea, if inclined.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, the registered provider had failed to provide a safe and effective service for residents that was compliant with the regulations. Inspectors found that there were significant concerns in relation to governance and management, staffing, infection control and residents rights. The inspectors reviewed unsolicited information received by the Office of the Chief Inspector. The information included concerns regarding staffing levels and cleanliness. This information was found to be substantiated on this inspection.

Foxberry Limited is the registered provider for this designated centre. This centre forms part of the Silverstream Nursing Home group which has many nursing homes throughout Ireland. A senior management team provided support to a person in

charge of the centre. This senior team consisted of a director of clinical governance and risk, quality manager, facilities and human resource manager.
This regional support team were responsible for ensuring that group management systems were implemented, and for ensuring the monitoring of the quality of service delivery. The management team within the centre consisted of the person in charge and two assistant directors of nursing. They were responsible for the supervision and support of a team of nurses, healthcare assistants, activity co-ordinators, housekeeping, catering and administrative staff.

This inspection found that there was ineffective management and oversight of the service. While the registered provider had some management systems in place to monitor and oversee the service, the senior management team did not identify that these systems were not being implemented, and subsequently, did not recognise the deterioration in the quality of care delivery, the quality of life of residents, or of the deterioration in the safety of the care environment.

Due to significant concerns and identified risks, inspectors issued a number of immediate actions on day one and day two of the inspection, and an urgent compliance plan was also issued to the registered provider following day two of this inspection. Satisfactory assurances were not received to this urgent compliance plan, and a third day of inspection took place. On the third day of the inspection, the inspectors followed up on the actions from the urgent compliance plan and found some of the issues had been addressed in relation to maintenance, but the staffing concerns remained.

Overall, the staffing levels and skill mix on the days of the inspection were not appropriate to meet the assessed care needs of residents. Residents were seen to be waiting to receive support for attention to personal hygiene needs, as well as waiting for assistance to go to bed. Furthermore, a review of call bell audits, dated 31 December 2025 and 29 January 2026, completed by the provider confirmed that residents waited from 5 to 10 minutes on occasion when assistance was sought. There were significant deficits in staffing resources from those outlined in the centre's statement of purpose. These deficits were in nursing, health care assistant, household and activity staffing. The impact of these deficits was found in the quality of care provided, and is further described throughout this report under Regulations 27: Infection control and Regulation 15: Staffing. The registered provider was endeavouring to respond to the gaps in the staffing, however, residents continued to be admitted to the centre despite this placing an additional workload on a reduced staffing resource.

There were insufficient numbers of housekeeping staff assigned to ensure appropriate standards of environmental hygiene on the days of the inspection. Cleaning records for some toilets were found to be last dated in October 2025. During the last outbreak, healthcare assistants were assigned the role of enhanced cleaning, alongside the care of the residents.

The maintenance oversight and resourcing systems were ineffective in relation to laundry and kitchen equipment. As identified on previous inspections, the laundry dryers remained non-operational due to an unresolved ventilation issue. As a result,

staff had to transport washed laundry from the external laundry to the internal old laundry on the third floor for drying, and then return it to the external laundry for sorting and distribution to residents` rooms. In the kitchen, the oven was not working properly**.**

Regulation 15: Staffing

There was inadequate staffing levels and skill mix to meet the assessed needs of the residents in the centre. This was evidence by;

- Inadequate levels of staff, for example, on the first day of the inspection there were 20 care hours which were unfilled due to unplanned leave and on the second day there was a 12 hour gap in the roster.
- Inadequate staff available to support residents with their hygiene needs. This was evidenced by inspectors observations of residents waiting for care whilst staff were busy. Furthermore, inspectors observed two residents waiting for over 30 mins to be assisted to bed.
- There was not enough staff employed to ensure effective cleaning of all areas of the centre. For example, there was one housekeeper working from 8am-4pm daily to clean the whole centre. This was a reduction in hours from the levels committed to in the statement of purpose (SOP). The hours were not increased during the recent infection outbreaks.
- There was inadequate provision of activities to provide 1-1 activities for those who required it.
- There were inadequate levels of health care assistants rostered on numerous occasions to meet the needs of the residents. A review of the roster found that there were three full-time healthcare assistant vacancies.
- There was no laundry staff provided for Saturday and Sunday.

An urgent compliance plan response was issued to the provider in relation to the levels of cleaning staff in the centre after the second day of the inspection. On the third day of the inspection, a review of the action taken found that housekeeping hours had not been increased sufficiently to clean the centre during an outbreak of infection.

Judgment: Not compliant

Regulation 16: Training and staff development

This inspection found that staff did not demonstrate appropriate knowledge and competence in the management of infection outbreaks and medicines.

Staff were not appropriately supervised to ensure that they carried out their work to the required standards. This was evidenced by the following findings:

- Supervision arrangements in place were ineffective to ensure a high standard of care delivery. For example, the oversight and supervision of medications did not fully ensure the safe administration of medicines.
- Supervision arrangements were not in place to ensure that environmental hygiene standards were in line with best practice standards for reducing the spread of infection.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- There was insufficient staffing resources available to provide safe quality care. This was evidenced by inspectors' observations, resident, visitor and staff interviews, a review of residents' dependencies as well as a review of staffing rosters.This was particularly evident in the standard of environmental hygiene in the centre over the three days of the inspection.
- There was also a full time nursing vacancy at the time of the inspection.

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

- Inadequate systems of nursing oversight to ensure that health and social care was delivered in line with residents assessed needs.
- Oversight of clinical documentation. Records, in relation to the health, condition and treatment given, was not fully in line with professional guidelines. For example, there were incomplete records of residents fluid intake, for residents who required to be monitored.
- The systems in place for ensuring that the centre was fully staffed on a daily basis was not effective. For example, there was poor oversight and management of unplanned leave.
- The system in place to oversee the notification of incidents to the Chief Inspector had failed to identify that all reportable incidents had been appropriately and timely notified.
- Management systems in place did not ensure that outbreaks were managed sufficiently to protect residents from infection and were not in line with best practice standards. This is discussed under Regulation 27: Infection control.
- The audit process was ineffective. For example, a falls audit had been completed, however, this audit did not link falls and staffing levels and staff supervision. Furthermore, the actions recommended in the audit were not

evident on days of inspection, for example, that nurses highlight at all handovers what safety measures are in place for residents who are at high risk of falling.
- The oversight and review of safeguarding incidents was not effective. For example, two of the three safeguarding incidents reviewed found that the assessments were not accurate and a third relating to unexplained bruising found that not all factors had been considered including a review of medication which may have been a contributory factor.

Under this regulation the provider was required to submit an urgent compliance plan to address the urgent risks. The provider's response did not provide assurance that the risks were adequately addressed.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the records in relation to incidents in the centre showed that there were one incident, as set out in Schedule 4 of the regulations that was not notified to the office of the Chief Inspector within the required time frames.

Judgment: Not compliant

Quality and safety

Ineffective systems of governance and management described in the capacity and capability section of this report impacted on the quality and safety of care provided to the residents in key areas such as staffing levels, infection prevention and control (IPC), residents` rights and premises.

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

Several potential contributory factors were identified on each day of the inspection which impacted on the management of outbreaks and increased the risk of further outbreaks. This included poor outbreak communication and oversight, poor environment and equipment hygiene, poor vaccination uptake for residents and staff and limited access to clinical hand- washing facilities. The person in charge had completed a review following the previous outbreaks and these issues had not been

identified as areas of concern. Findings in this regard are presented under Regulation 27: Infection control.

Inspectors noted that some areas of the centre required urgent maintenance attention to ensure residents safety. The issues identified were brought to the attention of the person in charge during the inspection, and the provider at the end of the inspection, and through an urgent compliance plan. The issues are discussed under Regulation 17: Premises and Regulation 9: Residents` rights.

Inspectors viewed a sample of residents electronic nursing notes and care plans. There was evidence that preliminary assessments to assess for safeguarding incidents were not completed in detail and that safeguarding careplans needed updating to reflect the needs of the residents, This is discussed under Regulation 5: Individual assessment and care plan.

Residents had access to television, radio, newspapers and books. Religious services and resources were also available. There was an advocacy service available with a dedicated person from the group available to assist. Details regarding this service were advertised on the resident information board, and displayed in the reception area of the centre.

There was an activity programme in place, however, this inspection found residents could not access 1:1 activities as required. In addition, residents' privacy and dignity was not fully upheld. The layout of some bath rooms did not ensure privacy for residents. Residents' meetings were convened regularly to ensure residents had an opportunity to express their concerns or wishes. However, concerns raised at residents meetings were not responded to, to ensure a satisfactory resolution for the residents. For example, residents had raised the concern about inadequate staffing levels and also the path around the garden was uneven for residents to walk around safely, and these concerns had not been addressed.

Inspectors 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 during the inspection. There were appropriate visiting restrictions in place, considering that the centre had an on-going outbreak of infection at the time of this inspection.

Regulation 11: Visits

There was appropriate visiting restrictions in place and visitors were observed coming and going to the centre on the days of inspection. Residents were able to meet with visitors in private or in the communal spaces through-out the centre.

Judgment: Compliant

Regulation 17: Premises

The registered provider failed to ensure that the premises conformed to the matters set out in Schedule 6 of the regulations. For example:

- The laundry service was located in a building external to the main building. The dryers had not been commissioned. This resulted in the inappropriate transfer of laundry through the building, posing a risk of cross infection to residents.
- An oven in the kitchen had been out of order for an extended period of time.
- The décor in some parts of the centre was showing signs of wear and tear. Surfaces and finishes including wall paintwork, floor covering and wood finishes in some resident rooms and communal areas were worn and as such did not facilitate effective cleaning. The design of the shower trays within the majority of the bathrooms did not facilitate effective cleaning and encouraged the accumulation of dirt and biofilms over the tiled surfaces.
- The outside path in the garden was uneven and this meant that residents could not walk safely in this area.
- The kitchen did not have a separate area to store cleaning chemicals, the chemicals for cleaning were stored in the managers office along side other equipment.
- The inspectors found that along one corridor when the toilet was being flushed it generated a very loud banging noise which was disruptive and impacted residents` ability to rest during the day.

An urgent compliance plan request was given after the second day of the inspection in relation to the broken oven and the dryers being commissioned. A new oven had been ordered and there was a date in place to commission the dryers.

Judgment: Not compliant

Regulation 26: Risk management

The registered provider failed to determine the specified risks as outlined in the regulations were assessed and that actions were in place as required. For example;

- The risks associated with the reduction in housekeeping hours had not been identified. The impact is described under Regulation 27: Infection control.
- The risks associated with the high turnover of staff in the last 12 months. The impact is described under Regulation 15: Staffing.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider did not ensure that IPC procedures, consistent with the standards published by the Authority were in place and were implemented by staff. For example:

- This inspection found that areas of the centre including the kitchen and residents` equipment were visibly unclean.
- The needles used for injections and drawing up medication lacked safety devices, in line with best practice guidelines. Some of the sharps boxes in use were not signed or dated and also did not have the temporary closure engaged.These omissions increased the risk of needle-stick injuries, which may leave staff exposed to blood borne viruses.
- Hand hygiene facilities were not in line with best practice and national guidelines in all areas of the centre. For example, clinical hand wash basins were not available in all resident areas for staff to wash their hands. The centre also does not have a designated treatment room with hand hygiene facilities for staff to wash their hands before preparing dressings or medications.
- Equipment used for cleaning high touch surfaces were left in the bathrooms for reuse. This meant that damp cloths that were reused had the risk of germs multiplying and spreading infection.
- Laundry was not managed in line with the centres own policy for managing linen. For example, some of the linen for soiled or infected linen were not placed in a red soluble bag to protect laundry staff from infection.

The registered provider did not ensure guidance published in relation to IPC and outbreak management was implemented. For example;

- All areas of the centre were not deep cleaned following a previous outbreak of norovirus and cleaning records showed that cleaning was not enhanced sufficiently during the outbreak. There were gaps in the cleaning records. This increased the risk of infection transmission. On the third day of the inspection the centre was in another outbreak of infection. The provider had not increased housekeeping hours sufficiently to support routine daily cleaning or enhanced cleaning.
- On the third day of the inspection the centre, there was no signage to alert visitors that the centre was in an outbreak of infection and staff working on night duty were not aware the centre was in an outbreak. This meant that precautions may not have been in place to protect other residents from infection.

Under this regulation the provider was required to submit an urgent compliance plan to address the urgent risks identified. The provider's response did not provide assurance that the risks were adequately addressed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of care plan records found that residents were not appropriately assessed, and therefore, care plans did not contain the detail required to ensure the needs of each resident were met.

- For example, a resident with safeguarding needs did not have an assessment of need completed and therefore, no care plan was developed to ensure that all staff were aware of the interventions required to ensure the residents safety.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider having regard to the care plan prepared under Regulation 5, provide appropriate healthcare in accordance with professional guidelines. As evidenced by;

- Care was not delivered in line with some residents care plan. For example: the delivery of IPC practices were not aligned to evidenced based guidelines to protect residents from developing a healthcare associated infection.
- Nursing documentation and communication did not align with best practice guidelines.

Judgment: Not compliant

Regulation 9: Residents' rights

A registered provider did not ensure that a resident can under take activities in private. For example;

- There were two bedrooms with ensuites where the residents could not close the door whilst using the toilet or have a shower. This was addressed on the third day of the inspection.
- Due to reduced staffing levels not all residents in their bedrooms could avail of activities to meet their individual needs. For example, 1:1 activities.

- Closed circuit television was in operation in areas where residents would be expected to undertake activities in private for example in day rooms, dining rooms and sitting rooms. There was limited signage to inform residents.

While resident meetings were held, the areas identified for improvement by the residents had not been addressed. For example, the uneven outside path in the outside garden and the lack of a canopy was highlighted as an issue at a residents meeting, however, no action to address the issue had been taken by the provider. This was a repeated finding from the previous inspection in July 2025.

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
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Nenagh Manor Nursing Home OSV-0000422

Inspection ID: MON-0049406

Date of inspection: 05/03/2026

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Staffing levels and skill mix were urgently reviewed following inspection against residents' assessed dependency levels and are now reviewed on a daily basis by the Management in the home. Immediate actions were implemented to address identified gaps, including the advance booking of agency staff to ensure full roster coverage. All previously identified roster deficits have now been addressed. • Housekeeping hours have been increased by 28 hours per week to ensure adequate cleaning of the centre. Additional contingency hours are in place and will be implemented immediately in the event of an outbreak. • Laundry services have been extended to operate 7 days per week, ensuring continuity of service. • A full-time Activity Coordinator is in post, and recruitment for an additional part-time Activity Coordinator has been completed, ensuring residents' social and engagement needs are consistently met. • The centre is currently operating with full staffing compliance. All shifts are filled, and staffing levels are sufficient to meet the residents needs, including care delivery, cleaning, laundry, and activities provision. Previously pre-booked agency shifts have been cancelled due to full staffing compliance and is only utilised as a contingency where required. • Governance and oversight systems have been strengthened by the Registered Provider Representative (RPR) team to ensure sustainability: o Rosters are planned in advance to ensure all shifts are filled o Agency staff is booked in advance where potential gaps are identified o Weekly staffing and recruitment review meetings are held with HR, with records maintained o Staffing risks are recorded on the risk register and escalated to the RPR team for oversight and action • The Provider assures that systems have been reviewed to ensure the service is safely operating and residents' needs are consistently met. The following evidence is available to support compliance: o Worked rosters demonstrating full shift coverage	

o Residents' dependency assessments aligned with staffing levels
o Recruitment records and interview logs
o Housekeeping and laundry rosters
o Activity schedules and staff allocation records
o Resident survey carried out on 31/03/2026 by Advocacy Manager
o Records of staff meetings across departments, including identified learnings and associated action plans

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• Immediate action was taken to strengthen clinical governance, staff supervision, and oversight within the centre. The Clinical Governance Team has maintained a daily presence in the home to review management structures, support staff, and ensure improvements in clinical practice are implemented and sustained.
• A full review of the management structure has been completed, with clear roles, responsibilities, and accountability defined for the PIC, ADONs, and CNMs. This ensures effective supervision of staff, clear escalation pathways, and consistent oversight of care practices.
• While the centre has a high level of training compliance, it was identified that greater emphasis was required on supervision and embedding learning into daily practice. This has been addressed through increased on-floor supervision, real-time coaching, and immediate feedback to staff.
• Targeted, thematic training sessions and staff huddles have been delivered to address identified gaps, particularly in:
o Infection Prevention and Control (IPC) and outbreak management
o Medication management and safe administration
o Clinical documentation, falls management and care planning
• Training is ongoing and aligned to identified needs, with records maintained on-site and available for review.
• Supervision arrangements have been significantly strengthened:
o Increased visible presence of senior nursing staff (CNM/ADON/PIC) on the floor
o Direct observation of staff practice with immediate corrective actions implemented where required
• Environmental hygiene practices are now close monitored:
o Clear allocation of responsibilities for cleaning and monitoring
o Regular management spot-checks across all areas of the centre
o Weekly site visits by the external cleaning contractor supervisor
o Monthly IPC audits completed by management in addition to contractor audits
• With the centre now operating at full staffing compliance and a clearly defined management structure, the communication, supervision, and accountability have improved across the service. This has supported the gradual improvement of staff practices in key areas.

Regulation 23: Governance and management	Not Compliant

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

• The Clinical Governance Team has provided direct on-site support, ensuring that identified risks were addressed and improvements implemented without delay.
• Management structures have been reviewed, with clear roles, responsibilities, and accountability defined for the PIC, ADONs, and CNMs. This ensures effective clinical and operational oversight across all areas of the service.
• Staffing levels have been stabilised and are now aligned with residents' assessed dependency levels - refer to Regulation 15. Systems are in place to ensure:
o Advance roster planning
o Daily review of staffing levels
o Timely escalation and contingency planning
• Clinical oversight has been significantly strengthened, refer to regulations 5 and 6:
o Daily review of incidents, complaints, and clinical risks by management
o Ongoing on-site presence of the CGT to support and monitor implementation of improvement plans until the service is stabilized.
o Care plan review systems and audit processes in place to track compliance and completion of actions.
o Ongoing supervision of documentation standards.
o Re-audits are conducted to specific areas to ensure sustained improvement.
o Weekly review of key risk areas at Clinical Governance meetings.
o Monthly review of clinical KPIs by the CGT, with findings shared with the PIC and ADONs to identify trends and implement action plans.
• Systems for incident and notification management have been reviewed and emphasized - refer to regulation 31, ensuring all reportable incidents are identified, escalated, and notified within required timeframes.
• Infection prevention and control processes have been enhanced - refer to Regulation 27:
o Strengthened outbreak management processes
o Increased environmental and IPC audits
o Improved oversight of cleaning and hygiene standards
o Audits findings are analysed, and action plans are implemented and monitored
• Risk Register has been reviewed and processes strengthened - refer to Regulation 26, ensuring risks are identified, assessed, controlled, and regularly reviewed.
• Communication and staff engagement have improved:
o Staff meetings held across all departments
o Daily handovers and safety discussions
o Clear escalation pathways for concerns
o Ongoing communication and follow up with residents and families

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All open incidents were reviewed, updated, and submitted to the Chief Inspector as required, with follow-up information provided where necessary. These included notifications relating to safeguarding, staffing, and other reportable incidents.
• A member of the Clinical Governance Team has been in contact with residents and/or their relatives, where appropriate, to ensure clear communication and provide reassurance regarding actions taken.
• A structured process is in place to ensure ongoing compliance:
o All incidents and complaints are reviewed on the day of occurrence by the Management in the home with oversight from Clinical Governance Team.
o A determination is made as to whether the incident/complaint is notifiable to the Office of the Chief Inspector
o Where clarification is required, this is discussed with the Clinical Governance Team to ensure timely and appropriate notification
o Serious incidents and complaints are reviewed at weekly Clinical Governance Meetings

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Immediate action was taken to address the key environmental risks identified during inspection. A new cooker/oven has been installed, and the kitchen is now fully operational. A deep clean of the kitchen has been completed and kitchen audits carried out with adequate action plans to ensure compliance with food safety and hygiene standards.
• Laundry services have been reviewed and are now fully operational. Dryers have been commissioned, and appropriate processes are in place to ensure the safe segregation and transfer of laundry, reducing the risk of cross infection. A new washing machine has also since been purchased and installed to replace one of the older machines.
• A condition survey of the premises has been completed, identifying areas requiring repair and upgrade, including flooring, painting, and general décor. Works are currently ongoing, with flooring repairs and replacement, and painting progressing throughout the centre. Painting work is being carried out as a weekly routine 2-3 days per week, every week until all painting is completed. Flooring refurbishment work will continue on a phased basis in accordance with room availability. Key areas have since been identified and work has commenced in bedrooms and corridor areas. Ensuite bathrooms are also having flooring upgrade works carried out and this work will continue on a phased basis.
• A plumbing issue which had caused pipe work noise has since been addressed by replacing washers on all affected cistern inlet fill valves and there has been no further issues with noise noted or reported.
• Housekeeping resources have been increased by 28 hours per week to support

improved environmental hygiene and ensure all areas of the centre are maintained to an appropriate standard.
• Additional environmental improvements are in progress:
o Installation of clinical hand wash sinks is scheduled for completion by 30/06/2026. The associated risk has been recorded on the Risk Register, with interim control measures in place and subject to ongoing review until works are completed.
o A schedule of works has been developed and is reviewed weekly by the Facilities Manager.
o Outside path repairs have been completed.
o Store of cleaning chemicals will be addressed by means of providing a suitable cabinet for chemicals. They will be removed from chef office and relocated, and this will be completed by 30/05/2026.
• All works are being tracked and overseen by management, with weekly progress reports completed by the Maintenance Officer and shared with the Facilities Manager.
• Environmental audits have been completed, and an action plan is in place to address any outstanding items identified, including follow-up from the recent audit conducted on 09/04/2026 by and an external consultant.
• Interim risk controls are in place for any outstanding works, including enhanced cleaning, supervision, and restricted use of affected areas where required, ensuring resident safety is maintained at all times.
• Domestic and Kitchen audits will be conducted monthly.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• The centre's risk register was reviewed and updated to ensure that risks associated with staffing levels and reduction in housekeeping hours were identified and formally assessed.
• The risk register has been updated to include:
o Risks relating to staffing shortages and staff turnover
o Risks associated with environmental hygiene and reduced housekeeping capacity
o Risks associated to residents' privacy and dignity.
• Control measures have been implemented to mitigate identified risks, including:
o Increased housekeeping hours by 28 hours per week
o Full staffing compliance and contingency arrangements through agency support
o Strengthened supervision and oversight of staff practices
o Enhanced environmental cleaning and monitoring processes
• The risk register is actively reviewed by the PIC on a regular basis and following any

incidents, audits, or identified non-compliances at the Health & Safety meetings and is subject to oversight by the Clinical Governance Team and PPIM during site visits.

Regulation 27: Infection control	Not Compliant

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

• Immediate action was taken to address the infection prevention and control risks identified during inspection. A deep clean of the centre, including the kitchen and residents' equipment, was completed, and enhanced cleaning standards have been implemented across all areas.

• Housekeeping resources have been increased by 28 hours per week, with additional contingency hours identified and implemented during outbreak situations to ensure adequate environmental hygiene and infection control.

• Safety needles have been introduced, and all sharps management practices have been reviewed. Sharps bins are now correctly assembled, signed, dated, and managed in line with best practice guidelines.

• Hand hygiene facilities have been reviewed, and clinical hand wash sinks installation is scheduled for completion by 30/06/2026 to ensure compliance with national IPC standards.

• Cleaning practices have been strengthened:

o Clear protocols are in place to prevent reuse of cleaning equipment

o Regular management spot-checks across all areas of the centre

o Weekly site visits by the external cleaning contractor supervisor

o IPC audits are conducted monthly, with associated action plans developed and monitored

• Laundry processes have been reviewed and reinforced:

o Staff have been re-educated on correct segregation of linen, including the use of red soluble bags for soiled and infected linen

o Compliance with the centre's laundry policy is monitored by management in the home through direct observation and competency checks

• Outbreak management procedures have been strengthened:

o The outbreak contingency plan has been reviewed and is in place, with a clear checklist to guide staff in its implementation.

o Staff are informed of outbreak status at each shift handover

o Enhanced cleaning schedules are activated immediately during outbreaks

• Staff knowledge and practice have been addressed through targeted IPC and outbreak management training, with a focus on ensuring that learning is embedded into daily practice through supervision and oversight.

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:
• Immediate action was taken to review care planning processes following inspection. The Clinical Governance Team identified and completed a review of high-risk residents' care plans, with clear identification of areas requiring amendment and improvement.
• All identified gaps have been addressed, and care plans have been updated to reflect residents' current needs, including safeguarding requirements, ensuring staff have clear and accurate guidance to support safe and effective care delivery.
• A care plan review tracker has been implemented, ensuring that all residents care plans are reviewed, updated, and maintained in line with best practice. Care plans amended by the nursing team are subsequently reviewed by PIC/ADON or a member of the CGT to ensure compliance with required standards.
• ViClarity audits have been completed, and the same residents will be re-audited following care plan updates to monitor improvement and ensure sustained compliance.
• The care plan tracker is live and is monitored weekly by the CGT, providing ongoing oversight and ensuring timely completion of required actions.
• Staff knowledge and practice have been strengthened through targeted care planning training, with a focus on:
o Comprehensive assessment of residents' needs
o Triangulation of information
o Development of person-centred care plans
o Clear documentation of safeguarding and risk management interventions

Regulation 6: Health care	Not Compliant

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

Outline how you are going to come into compliance with Regulation 6: Healthcare:

• Immediate action was taken to review clinical care delivery following inspection. All residents have an up to date GP review, and identified healthcare needs have been addressed, ensuring care is delivered in line with individual care plans and the centre's policies & procedures.
• GP engagement has been conducted through formal communication and review of service arrangements, ensuring improved access to timely medical review and continuity of care.
• Clinical oversight has been improved through focused review of key risk areas,

including:
o Falls management
o Wound care and pressure ulcer management
o Weight management and nutritional status
o Management of MDROs
Action plans have been developed and implemented for each area to ensure appropriate assessment, intervention, and ongoing monitoring.
• The Clinical Governance Team conducts a monthly review of clinical KPIs, with reports shared with the PIC and ADONs for further analysis of identified risk areas and implementation of appropriate action plans. A comprehensive review of falls and wound management has been completed, with improvement plan implemented.
• A structured approach to clinical review is now in place:
o High-risk residents are identified and prioritised for review
o Care plans and risk assessments are updated to reflect current clinical needs
o Clinical progress is monitored through scheduled and Ad Hoc audits, and review analysis.
• Multidisciplinary Team (MDT) input is in place and services were reviewed, including dietician, speech and language therapy, physiotherapy, chiropody, and tissue viability nursing, ensuring a timely and comprehensive review when needed.
• Staff knowledge and care practices have been reinforced through targeted training and supervision, ensuring care delivery aligns with care plans and best practices.
• IPC practices have been reviewed and improved to prevent healthcare-associated infections, with ongoing supervision and audits.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The RPR team has taken adequate action to address concerns related to privacy and dignity. Issues relating to ensuite doors have been resolved, ensuring that residents can maintain privacy while using toilet and shower facilities. When resident doesn't agree with appropriate actions, same is identified in the risk register with measures in place to ensure resident s privacy is maintained.
• Staffing levels are back to full compliance, enabling residents to access both group and 1:1 activities in line with their preferences and assessed needs. Residents requiring individual engagement have been identified, and 1:1 activities are scheduled, recorded and monitored, ensuring equitable access.
• Recruitment for an additional part-time Activity Coordinator is ongoing. In the interim, a Healthcare Assistant is allocated to support activity provision, ensuring residents' social and engagement needs are consistently met.
• The use of CCTV and its policy have been reviewed. Appropriate signage is in place to inform residents and visitors, ensuring transparency and respect for residents' rights.
• Resident feedback is encouraged and welcomed:

o A resident survey was completed on 31/03/2026, and findings are part of an action plan
o Actions arising from residents' meetings are now tracked and monitored to completion. Previous findings related to outside path is now resolved.
• Environmental concerns raised by residents, including the uneven garden path and outdoor facilities, have been acknowledged and are being addressed as part of the centre's maintenance and improvement plan.

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	Red	20/04/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	20/04/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	20/04/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Red	30/06/2026

	provide premises which conform to the matters set out in Schedule 6.			
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	Red	20/04/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	20/04/2026
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	20/04/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the	Not Compliant	Red	30/04/2026

	Authority are in place and are implemented by staff.			
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 implemented in the designated centre, as required.	Not Compliant	Red	30/06/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	20/04/2026
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.	Substantially Compliant	Yellow	30/04/2026

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	Red	30/04/2026
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	20/04/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Red	20/04/2026
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the	Not Compliant	Orange	20/04/2026

	organisation of the designated centre concerned.			