



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

Issued by the Chief Inspector

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| Name of designated centre: | St. Theresa's Nursing Home |
| Name of provider: | Ormond Healthcare Ltd |
| Address of centre: | Dublin Road, Thurles, Tipperary |
| Type of inspection: | Unannounced |
| Date of inspection: | 28 October 2025 |
| Centre ID: | OSV-0000434 |
| Fieldwork ID: | MON-0048349 |

About the designated centre

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

St. Theresa's Nursing home was established in 1980 and is located on the outskirts of the town of Thurles in close proximity to shops, restaurants and other facilities. It is a two-storey premises with bedroom accommodation on both floors and communal accommodation on the ground floor only. Accommodation on the first floor comprises ten single bedrooms. Two of the bedrooms on the first floor have full en suite facilities with toilet, shower and wash hand basin and all of the other bedrooms have a wash hand basin. Access to the first floor is by stairs and chair lift. Accommodation on the ground floor comprises 16 single bedrooms. There are three assisted bathrooms on the ground floor, each of which have an assisted shower, a toilet and a wash hand basin and a separate toilet with hand basin. There is a dining room adjacent to the kitchen on the ground floor. Communal space consists of two sitting rooms and a separate room that can be used by visitors. There is also a nurses' office on the ground floor that is located in close proximity to the communal living rooms. The provider is a company called Ormond Healthcare Limited. The centre provides care and support for both female and male residents aged 18 years and over. Residents 50 years and over with dementia and or a physical disability can also be accommodated. Care is provided for residents over age of 50 years requiring convalescent, respite and palliative care. Pre-admission assessments are completed to assess each resident's potential needs. Based on information supplied by the resident, family, and / or the acute hospital, staff in centre aim to ensure that all the necessary equipment, knowledge and competency are available to meet residents' needs. There is 24-hour care and support provided by registered nursing and healthcare assistant staff with the support of housekeeping, catering, administration, laundry and maintenance staff.

The following information outlines some additional data on this centre.

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| Number of residents on the date of inspection: | 26 |
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

| Date | Times of Inspection | Inspector | Role |
|------------------------------|-------------------------|------------------|------|
| Thursday 13 November 2025 | 08:45hrs to 13:30hrs | Rachel Seoighthe | Lead |
| Tuesday 28 October 2025 | 09:30hrs to 17:40hrs | Rachel Seoighthe | Lead |

What residents told us and what inspectors observed

This unannounced inspection was completed over two days. Overall, the inspector found that residents were content with living in the designated centre and comfortable in the company of staff, who were observed to be attentive to residents' needs.

The inspector was greeted by the person in charge upon arrival to the centre. Following an introductory meeting, the inspector walked through the centre, giving an opportunity to meet with residents and staff. Many residents were relaxing in the main communal sitting rooms, and some residents were receiving assistance with their personal care needs in their bedrooms. The atmosphere in the centre was bustling.

St Theresa's Nursing home was a purpose built, two-storey building, located on the outskirts of Thurles town, Co. Tipperary. The designated centre was registered to provide care to a maximum of 26 residents. The centre was fully occupied on the day of inspection. Outdoor communal areas consisted of an enclosed courtyard garden, which was accessible without restriction.

On the walk through the premises, the inspector noted that the centre provided a homely environment for residents. There were two sitting rooms with sufficient seating to ensure residents had comfortable communal spaces. A visitors room was available for resident use.

Resident bedroom accommodation was provided in single bedrooms, laid out over both floors, which were accessible by stairs and a chair lift. The first floor of the centre comprised 10 single bedrooms and there were 16 single bedrooms on the ground floor of the centre. The inspector observed that resident bedrooms were generally clean and tidy. It was evident that residents were encouraged to personalise their bedrooms, with items of significance, such as family photographs, ornaments and soft furnishings. Televisions and call bells were provided in all resident bedrooms.

Overall, the premises was clean and well-maintained. However, the inspector noted that there was storage of residents' assistive equipment in the treatment room. The inspector found that some areas of the centre were not fully secure and posed a risk to residents who required a high level of supervision. There were some residents living in the centre with poor safety awareness who demonstrated exit seeking behaviours. As they walked through the centre, the inspector observed that an alarm was not functioning on a fire exit door on the first floor, leading to a ground floor stairwell. The inspector noted that a window at the bottom of the stairwell was fully openable, and the exit door adjacent to the window was unsecured. The inspector observed that this exit door could be opened easily, and, without the knowledge of staff, as it was not alarmed. This arrangement posed a risk to resident

safety, as it gave unrestricted access to the grounds at the front of the centre, which was located on a busy public road. This risk was addressed by the provider on the day of inspection.

Following a previous inspection, the provider had converted a former treatment room into a bedroom. The inspector noted that there was a sharp narrow turn from the bedroom door, leading onto the corridor outside. The provider had specified in the statement of purpose, that only residents with low to medium dependency needs, would be accommodated in this room, to ensure that residents could be safely evacuated in the event of a fire safety emergency. However, the inspector found that this accommodation arrangement was not in place on the day of the inspection.

The inspector spent time chatting with, and observing residents in the various areas of the centre. Residents were seen resting in bed, or spending time in the communal sitting rooms, where there was a constant staff presence. Throughout the inspection, staff were observed assisting residents with their care needs, as well as supporting them to mobilise to different communal areas within the building. Some residents required greater time and support to mobilise, and staff provided this support in a gentle manner. A number of residents told the inspector that staff were kind, and that they were happy with the quality of the service received. Residents reported satisfaction with the quality of food and with the length of time it took for staff to respond to their requests for assistance.

A programme of activities was displayed for resident information, and two staff were assigned to the provision of activities for residents on a daily basis. The inspector observed that there was a sociable atmosphere in the communal sitting room where activities, such as card games, were taking place. A small number of residents preferred to spend time independently in their bedrooms and they told the inspector that their preference was respected.

The inspector observed visitors attending the centre on the day of the inspection. Residents were facilitated to receive visitors as they wished.

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

Capacity and capability

This was an unannounced inspection, conducted by an inspector of social services, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended). The inspector

also reviewed the detail of statutory notifications submitted to the Chief Inspector in relation to unexplained absences from the centre.

This inspection found that the provider had not fully implemented a compliance plan, in relation to premises, fire precautions, staffing, records and governance and management, submitted following the previous inspection of the centre in January 2025. This inspection found that there was significant non-compliance in relation to Regulation 23: Governance and management.

Prior to this inspection, the Chief Inspector had been notified of several incidents whereby a resident with enhanced supervision needs, had left the centre without the staff's knowledge of their whereabouts. Following each of these incidents, the provider had committed to implementing risk mitigating measures, including weekly audits of safety checks. This inspection found that the number of residents who required continuous supervision had increased, however, there were inadequate staffing resources available to meet the residents' care and support needs. Furthermore, the inspector found that there were areas of the care environment which were not secured on the day of inspection. These risks were not identified, assessed, and recorded within the centre's risk register, or escalated to the provider, by the management team. On the day of inspection, the provider was required to take immediate action to ensure that the care environment was safe and secure, and to ensure that there were appropriate staffing levels in place.

The provider was required to submit an urgent compliance plan to the Office of the Chief Inspector following day one of this inspection, to give assurance that there are adequate staffing resources available, to meet the assessed needs of residents in the centre. The provider was further required to give assurance that there was an escalation pathway within the organisational structure of the centre, that ensured appropriate risk management systems were in place. The urgent compliance plan submitted was accepted. A second day of inspection was scheduled to review the actions committed to by the provider. The inspector found that some improvements were made.

The designated centre is operated by Ormond Healthcare Limited, a company comprising two directors. The management structure had changed since the inspection of the centre in January 2025. A person in charge was appointed in August 2025 and they worked full-time in the centre. A regional operations manager was appointed to provide senior clinical oversight. The person in charge was supported by a newly appointed clinical nurse manager, who deputised in their absence. A team of nursing staff, health care assistants, housekeeping, catering, activity and maintenance staff made up the staffing compliment. Staff were facilitated to attend training that was appropriate to their role. This included fire safety, safeguarding of vulnerable adults, moving and handling practices and the management of responsive behaviours.

The registered provider did not ensure that there were sufficient staffing resources in place to ensure the effective delivery of care. A review of the centre's staffing roster on the day of inspection found that the staffing levels and skill mix were not appropriate to meet the assessed health and social care needs of the residents, in

particular residents, with complex needs who required continuous supervision. Records demonstrated that this was an ongoing risk, which had not been escalated to the provider by the management team. This inspection found that the specific roles, responsibilities, and accountability of the management team in relation to the supervision and oversight of the service, particularly in relation to risk management were not clearly defined. The pathway of escalation to the registered provider was unclear.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. The centre's own risk management system was not implemented. Risks, such as the inadequate supervision of residents with complex care needs were not identified by the management team. Clinical and environmental risks were not routinely assessed, recorded or monitored. Management oversight of key clinical care areas was not effective. For example, records demonstrated that the prevalence of healthcare associated infection (HCAI) was recorded in nursing records. However, this information was not routinely analysed to identify trends, detect increases in the incidence of infection, or recognise potential outbreaks early, to prevent onwards transmission. Systems of communication were not sufficiently robust. Staff meeting records were unavailable to view on the day of inspection. Clinical governance meetings records were poorly maintained and it was unclear how these communication systems provided oversight of clinical care. An annual review of the quality and safety of care delivered to residents in the centre for 2024 was not available to review on the day of inspection.

An electronic record of all accidents, incidents and complaints involving residents that occurred in the centre was maintained. Several notifiable incidents were not submitted to the Chief Inspector, in line with regulatory requirements.

A review of a sample of the contract for the provision of services in place for residents found that several residents who were admitted to the centre did not have contract of care in place. This is detailed under Regulation 24: Contracts for the provision of care services.

The registered provider did not maintain records, as required under Schedule 2 and Schedule 4 of the regulations. For example, a full and complete employment history was not retained in respect of staff were working the centre on an adhoc basis. This is detailed under Regulation 21: Records.

Regulation 15: Staffing

The number and skill mix of staff was inadequate with regard to the needs of the residents, and the size and layout of the designated centre. For example:

- Rosters evidenced that residents with complex care needs, who were assessed as requiring continuous supervision by staff, did not have this level of supervision in place consistently. This posed a risk to resident safety.

- There were occasions where the roster was required to be supplemented by staff employed in another designated centre.

Judgment: Not compliant

Regulation 16: Training and staff development

There were arrangements in place to ensure that staff were facilitated to access training in areas such as fire safety, safeguarding of residents, and moving and handling practices.

Judgment: Compliant

Regulation 21: Records

Records were not managed in line with regulatory requirements. For example:

- The staff duty roster reviewed did not contain the names of some staff who were working in the centre.
- A full and complete employment history was not retained in respect of all staff who were working the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that the service had sufficient staffing resources in place to meet the assessed care and supervision needs of the residents, in particular, resident with enhanced supervisory needs.

This inspection found that the specific roles, responsibilities, and accountability of the management team in relation to the supervision and oversight of the service were not clearly defined. The pathway of escalation to the registered provider was unclear.

Following the inspection, the provider was required to submit an urgent compliance plan to the Office of the Chief Inspector, to give assurance that there are adequate staffing resources in place, to meet the assessed needs of residents in the centre. The provider was required to provide assurance that there was an escalation

pathway within the organisational structure of the centre, that ensured appropriate risk management systems were in place. The urgent compliance plan was accepted.

Management systems were insufficiently robust to ensure the service provided was safe, appropriate and effectively monitored. For example;

- The system in place to manage risk was not effectively utilised. Risks in relation to the care environment had not been identified and managed.
- The registered provider had not ensured that record management systems were effectively implemented, and not all records set out in Schedule 2 were kept in the designated centre.

The provider was not operating the centre in accordance with their statement of purpose which stated that a bedroom on the ground floor accommodated residents with only low to medium dependency, due to its limited evacuation space for a higher dependency resident with reduced mobility.

An annual review of the quality and safety of care delivered to residents for 2024 was not available in the centre on the day of the inspection, as required by the regulations.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A review of a sample of contracts of care found that two residents did not have a contract of care in place. A third contract viewed was unsigned and incomplete.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had failed to submit notification of an unexpected death of resident, and an injury to a resident that required hospital admission, to the Chief Inspector, as required by the regulations.

Judgment: Not compliant

Quality and safety

Residents living in the centre were generally satisfied with the quality of the service they received. Residents had access to general practitioners (GPs), allied health professionals, specialist medical and nursing services. Residents voiced satisfaction with the programme of activities and the choice and quality of food available. The inspector observed staff engaging with residents in a kind and gentle manner. However, the inspector found that fire precautions, and the premises did not align fully with the requirements of the regulations. Furthermore, individual assessment and care planning and infection control did not meet the requirements of the regulations.

Resident care records were maintained on an electronic care record system. Following admission, a range of clinical assessments were carried out, using validated assessment tools to identify areas of risk specific to each resident. The outcomes of these assessments were used to develop an individualised care plan for each resident, which addressed their individual abilities and assessed needs. However, the inspector found that a comprehensive individual assessment was not always undertaken, and care planning documentation did not always contain up-to-date information to guide staff to meet the needs of the residents. For example, care plans developed for several residents who exhibited responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) did not contain up-to-date detail regarding the resident's supervisory needs, as described to the inspector by the person in charge on the day of inspection.

Overall, the design and layout of the premises was suitable for its stated purpose and met the residents' individual and collective needs. The centre was found to be well-lit and warm and resident's accommodation was individually personalised. However, there was visible wear and tear in some areas and inappropriate storage of resident mobility equipment in the treatment room.

There were measures in place to protect residents against the risk of fire. These included regular checks to ensure that equipment was accessible and functioning. Staff had received fire safety training and regular fire drills had been completed to ensure that resident could be evacuated in a safe and timely manner. However, the recorded drills did not provide assurance that residents could be safely evacuated to a place of safety in a timely manner. A sample of fire drills viewed involved the simulated evacuation of one resident rather than an entire compartment.

Infection prevention and control measures were in place and monitored by the person in charge. While the resident bedroom and communal accommodation was found to be clean, a number of issues which had the potential to impact on effective infection prevention and control were identified during the course of the inspection. The monitoring systems in place failed to identify a potential outbreak of acute respiratory infection (ARI). Approximately 23 % of residents had developed symptoms of respiratory infection in a two week period. However, a potential acute

respiratory infection (ARI) outbreak was not detected and managed in a timely manner. This is detailed further under Regulation 27.

Documentation completed for the temporary transfer of residents' to hospital was unavailable to view in four resident records. This did not give assurances that all relevant information about the residents was sent to the receiving hospitals.

Residents were reviewed by a medical practitioner, as required. Referral systems were in place to ensure residents had access to health and social care professionals for additional professional expertise.

Residents had access to television, radio, newspapers and books. Religious services and resources were available. A programme of activities was available to residents which included exercises, games and individual activities. There was an independent advocacy service available and details regarding this service were advertised on the resident information board, displayed in the reception area of the centre. Residents' meetings were convened regularly to ensure residents had an opportunity to express their concerns or wishes.

There were no visiting restrictions in place. The inspector found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished.

Regulation 17: Premises

There were areas of the building that did not meet the requirements under Schedule 6 of the regulations. For example:

- There was insufficient storage space for equipment, resulting in the inappropriate storage of equipment, such as a hoist and crash mattress in a treatment room. This was a repeated finding.
- There was damage to a dresser in one resident bedroom and a drawer handle was missing.
- There was damage to a wall socket in one resident bedroom and wiring was exposed.
- Paintwork was scuffed in a small number of resident bedrooms.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider did not meet the requirements of Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018). For example;

- A potential acute respiratory infection (ARI) outbreak was not detected and managed in a timely manner. Multiple residents had required treatment for respiratory illness over a two week period. While one resident had received COVID-19 antigen testing, there was no evidence that testing for influenza A or B, COVID-19 and Respiratory syncytial virus (RSV) testing was undertaken for any resident, in line with national guidance. Furthermore, general outbreak control measures such as active surveillance were not implemented. The failure to respond to the potential outbreak in line with local guidelines impacted effective infection prevention and control within the centre, and may have contributed to onwards transmission.
- The equipment used to wash and disinfect continence equipment was not serviced and maintained as required.

Judgment: Not compliant

Regulation 28: Fire precautions

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

- There was no call bell provided in the external smoking area.

The registered provider did not make adequate arrangements for maintaining of all fire equipment. For example:

- Emergency lighting was not operating in some parts of the centre. This may delay the direction of residents and staff to the emergency exit in the event of a fire.

The provider did not have adequate arrangements in place for the containment of fire. For example:

- There was a visible gap underneath the door of one bedroom on the first floor.
- A cross corridor fire door on the first floor of the centre did not form an effective seal when closed.

The arrangements for staff of the designated centre to receive suitable training in fire prevention emergency procedures were inadequate. For example:

- Simulated fire evacuation drills were taking place in the centre, however, they did not clearly detail the number of participants who were actively involved in the simulation and the type of equipment used to evacuate each resident.

This information is required to assure the provider that residents can be safely evacuated in a timely manner, in the event of a fire emergency in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A comprehensive assessment of residents needs was not completed for all resident living in the centre. A review of the care records of a resident who displayed a responsive behaviour found that this information was not recorded in several comprehensive assessments completed for the resident since their admission to the centre.

The supervisory arrangements described to the inspector by the management team did not align with the information contained in two residents' care plans.

Some residents' care plans were not reviewed in response to their changing needs. For example,

- A nutritional assessment completed for three residents indicated that they were at high risk of malnutrition. However, the resident care plans were not updated reflect this change, to direct staff regarding the interventions required to ensure the residents nutritional needs were met.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) of their choice. A referral system was in place for residents to access health and social care professionals such as dietitians, physiotherapists, psychiatry of late life and end of life services.

Judgment: Compliant

Regulation 9: Residents' rights

There was a varied programme of daily activities in the centre for residents to participate in, if they chose to. The registered provider had ensured that residents were consulted about the management of the designated centre through

participation in residents meetings and undertaking resident surveys. Resident had access to an independent advocacy service.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The nursing documentation completed for the temporary discharge of residents to hospital was not available for review in four individual residents records.

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 | Compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Quality and safety | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 27: Infection control | Not compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and care plan | Not compliant |
| Regulation 6: Health care | Compliant |
| Regulation 9: Residents' rights | Compliant |
| Regulation 25: Temporary absence or discharge of residents | Not compliant |

Compliance Plan for St. Theresa's Nursing Home OSV-0000434

Inspection ID: MON-0048349

Date of inspection: 28/10/2025

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

| Regulation Heading | Judgment |
|--|---------------|
| Regulation 15: Staffing | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider ensures that staffing levels and skill mix are maintained in accordance with the centre's Statement of Purpose and are based on the assessed needs of residents in line with Regulation 5, taking account of the size and layout of the centre. Daily roster planning is overseen by the Person in Charge and Clinical Nurse Manager to ensure that the rostered staffing complement and skill mix are appropriate to meet residents' needs. Where residents are assessed as requiring enhanced supervision, including one-to-one supervision or increased observation, this is arranged and clearly reflected on the daily roster.</p> <p>The centre has a defined escalation and contingency staffing pathway to ensure continuity of care in the event of unplanned absences, increased resident dependency, or emerging supervision needs. This includes the use of internal relief resources and overtime arrangements where required. Any staffing shortfalls or supervision risks are escalated promptly in line with the centre's escalation pathway to ensure timely management oversight and corrective action.</p> <p>Staffing and supervision arrangements are monitored through routine management oversight and governance review. Staffing risks, including risks relating to unplanned absences and enhanced supervision needs, are recorded on the risk register with named risk owners, control measures, and escalation triggers. Staffing levels, supervision arrangements, and relevant incidents are reviewed through the centre's governance structures to ensure that staffing remains appropriate, responsive, and safely managed. Through active roster oversight, responsive supervision arrangements and a clear escalation and contingency staffing pathway, the Registered Provider is assured that staffing levels and skill mix are appropriate and will be sustained to achieve and maintain compliance with Regulation 15.</p> | |

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| Regulation 21: Records | Substantially Compliant |
| <p>Outline how you are going to come into compliance with Regulation 21: Records: The Registered Provider is putting formal systems in place to make sure that all records required under Schedule 2 and Schedule 4 of the Regulations are complete, accurate, up to date and easy to access.</p> <p>A full audit of all staff files is currently underway to ensure compliance with Schedule 2 and Schedule 4 requirements, including verification of employment history, references, Garda vetting, qualifications and professional registration where applicable. Any identified gaps are being rectified without delay and are tracked through a newly introduced action log until fully resolved. Where full employment histories were incomplete, these have been obtained retrospectively and placed on file.</p> <p>The Registered Provider will introduce a centralised staff file tracker to monitor file completeness, outstanding documentation and renewal dates, including Garda vetting expiry, professional registration renewal and mandatory training certification. The tracker will be reviewed monthly by the Person in Charge and Administrator to ensure that all statutory and regulatory requirements are met on an ongoing basis.</p> <p>To address roster accuracy and traceability, a revised roster control process will be introduced to ensure that all staff working in the centre are named on the duty roster for each shift. This will include a daily roster verification check by the Person in Charge or designated senior staff member to confirm that the roster accurately reflects the staff on duty, including relief and additional supervision of staff. Any discrepancies identified will be corrected promptly and reviewed through governance where required.</p> <p>Records management is now built into the centre's audit and governance systems. A quarterly records audit programme is being introduced, with findings reported through Clinical Governance Meetings and escalated where non-compliance or risk is identified. Corrective actions arising from audits are assigned to named owners, tracked to completion and overseen by management.</p> <p>The Registered Provider Representative maintains oversight of records compliance through review of quarterly audit findings, monitoring of outstanding actions and escalation of any recurring or systemic issues.</p> <p>Through the introduction of clearer record-keeping processes, a full staff file audit, a planned tracking system, a revised roster control process, routine governance oversight and provider-level assurance, the Registered Provider is satisfied that records management systems will be robust, sustainable and will achieve and maintain full compliance with Regulation 21.</p> | |

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|--|---------------|
| Regulation 23: Governance and management | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Registered Provider has redesigned and strengthened the centre’s governance and management systems to ensure that the service is safe, appropriate, consistent and effectively monitored on an ongoing basis, and to address the systemic governance failures identified at inspection.</p> <p>A clear governance structure is now in place, with defined roles, responsibilities and accountability for the Person in Charge, Clinical Nurse Managers, Operations Manager and Registered Provider Representative. Responsibilities for staffing oversight, supervision of residents with enhanced needs, risk management, record keeping, infection prevention and control, safeguarding and regulatory compliance have been clarified and embedded into daily practice.</p> <p>A formal escalation pathway has been introduced to ensure that risks are identified early, escalated promptly, and acted upon consistently. The escalation pathway sets out clear triggers, timeframes and documentation requirements and applies to staffing shortfalls, supervision risks, safeguarding concerns, infection outbreaks, environmental hazards, and serious incidents. The pathway of escalation to the Registered Provider Representative is now clearly defined and is used in practice, with escalation activity monitored through governance meetings and provider oversight.</p> <p>To address insufficient staffing oversight for residents with enhanced supervision needs, governance controls have been strengthened to ensure that enhanced supervision requirements are identified, resourced, and monitored. Where residents are assessed as requiring one-to-one or increased observation, this is reflected on daily rosters, and any risk to safe staffing levels is escalated immediately through the escalation pathway for management action.</p> <p>The centre’s risk management system has been strengthened and is now used as a live governance tool. The risk register has been expanded to include risks relating to staffing, resident supervision, infection prevention and control, fire safety, and environmental hazards. Each risk has defined control measures, named risk owners, review dates, and escalation triggers. Environmental risks are now actively identified, recorded and monitored, and learning from incidents is fed back into the risk management process.</p> <p>Record management systems have been strengthened to ensure compliance with Schedule 2 requirements. A full audit of staff files is underway to address gaps in employment histories and required documentation. Clear processes are being introduced to ensure that all required records are maintained, audited and overseen through governance structures, with corrective actions tracked to completion.</p> <p>The Statement of Purpose has been re-embedded into operational governance.</p> <p>Admission and accommodation decisions are now formally checked against the Statement of Purpose to ensure that residents are appropriately placed in line with dependency levels and evacuation capability. The use of the ground-floor bedroom room 18 is now aligned with the approved accommodation criteria, and any proposed deviation is subject to formal risk assessment and provider approval.</p> <p>The Annual Review of Quality and Safety of Care for 2024 had been completed but could not be accessed on the day. This is now in hard copy format for review in the centre. 2025 review is currently under review and will be available in the centre and this now has been embedded into the governance cycle. An action plan arising from the review is</p> | |

monitored through governance meetings, with progress tracked and overseen by the Registered Provider Representative.

Structured Clinical Governance Meetings have been introduced and are held monthly, with standing agenda items including staffing and supervision, risk management, safeguarding, prevention and control, incidents and notifications, complaints, audit findings and quality indicators. Meetings are minuted, actions are assigned to named owners and tracked to completion, and unresolved risks are escalated for further management oversight.

A structured audit programme is being implemented across key risk areas, including staffing, care planning, infection prevention and control, records, notifications, fire safety and complaints management. Audit findings are reported through governance meetings, and corrective actions are assigned, tracked, and reviewed to ensure sustained improvement.

A new Person in Charge has been appointed and has completed a structured induction programme covering governance systems, the escalation pathway, risk management processes, infection prevention and control oversight, safeguarding governance, regulatory compliance and notification requirements. The Person in Charge holds day-to-day accountability for clinical governance, staffing oversight, risk register management, incident management, and audit implementation.

The Registered Provider Representative maintains direct oversight of governance and management systems through regular on-site visits, scheduled governance support meetings with the Person in Charge, joint review of the risk register, oversight of escalation activity and monitoring of audit outcomes. Provider oversight ensures that risks are identified early, acted upon promptly and monitored to resolution.

Through the introduction of a revised governance structure, a formal escalation pathway, strengthened staffing oversight for residents with enhanced needs, an expanded and actively used risk register, improved record management controls, re-embedding of the Statement of Purpose, completion of the Annual Review of Quality and Safety, a centre-wide audit programme, a strengthened Person in Charge role and direct provider oversight, the Registered Provider is satisfied that governance and management systems are now robust, transparent and sustainable and will achieve and maintain full compliance with Regulation 23.

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| Regulation 24: Contract for the provision of services | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

The Registered Provider has taken immediate action to address the findings in relation to contracts of care and has strengthened systems to ensure that all residents have a complete and signed contract of care in place.

The contracts of care for the two residents who did not have a contract in place have

now been completed and signed. The incomplete and unsigned contract identified at inspection has been fully completed and signed. All contracts are now held on the relevant resident files and are readily accessible.

A full audit of all resident contracts of care is currently underway to ensure that all contracts are present, signed, complete and reflect the correct terms, fees and services provided. Any gaps or discrepancies identified through the audit are being rectified without delay and are tracked through an action log until fully resolved.

A new admission checklist is being introduced to ensure that a contract of care is completed, signed and placed on file for all new admissions. This checklist is completed by the Administrator and reviewed by the Person in Charge to provide management oversight and assurance.

Contract management is now reviewed through the centre's audit programme and governance meetings. A quarterly contracts of care audit programme is being introduced, with findings reported through Clinical Governance Meetings and escalated where non-compliance or risk is identified. Corrective actions arising from audits are assigned to named owners, tracked to completion and overseen by management.

The Registered Provider Representative maintains oversight of contract compliance through review of quarterly audit findings and monitoring outstanding actions.

Through the immediate completion of outstanding contracts, the introduction of a new admission checklist, a centre-wide contract audit programme, routine governance oversight and provider-level assurance, the Registered Provider is satisfied that contract management systems are now robust, sustainable and will achieve and maintain full compliance with Regulation 24.

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| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The Registered Provider has taken immediate action to address failures in statutory notifications and has strengthened systems to ensure that all notifiable incidents are identified, reported to the Chief Inspector within the required timeframes and monitored on an ongoing basis.

The outstanding notifications in respect of the unexpected death of a resident and the injury to a resident requiring hospital admission have now been submitted. Responsibility for statutory notifications has been formally clarified, with the Person in Charge holding overall accountability and Clinical Nurse Managers responsible for escalating all potentially notifiable incidents without delay.

A clear statutory notification process has been introduced to set out what incidents are notifiable, the reporting timelines, who is responsible for submission and how notifications are documented. This process explicitly includes unexpected deaths and injuries requiring hospital admission.

Notification compliance will be monitored through a monthly audit, with findings reviewed at governance meetings and escalated where required.

The Registered Provider Representative maintains oversight of notification compliance through review of audit findings and escalation of any recurring or systemic issues.

Through the submission of outstanding notifications, clarification of accountability, the introduction of a formal process, routine audit and provider oversight, the Registered Provider is satisfied that notification systems will achieve and maintain full compliance with Regulation 31.

Regulation 17: Premises

Substantially Compliant

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

The Registered Provider has taken immediate action to address the environmental deficits identified at inspection and has strengthened systems to ensure that the premises now meets the requirements of Schedule 6 of the Regulations and is safe, suitable and well maintained.

Inappropriate storage of equipment is being addressed. The hoist and crash mattress have been removed from the treatment room and relocated to appropriate designated storage areas. Additional storage arrangements have been identified, and work will commence to put in place to ensure that equipment is stored safely and does not obstruct clinical or resident care areas.

The damaged dresser in a resident's bedroom has been replaced, and the missing drawer handle has been fitted. The damaged wall socket with exposed wiring has been made safe and repaired by a qualified electrician. All identified electrical and furniture defects have now been addressed.

Scuffed paintwork in resident bedrooms has been repaired as part of a targeted redecoration programme for 2026, with works prioritised in areas identified at inspection. A rolling painting and maintenance schedule has been introduced to ensure ongoing upkeep of the environment.

A formal environmental maintenance programme is being introduced, including routine premises checks, a maintenance log and a system for reporting and tracking repairs to completion. The Person in Charge oversees environmental safety checks, and the maintenance team are responsible for completing repairs in a timely manner.

Premises risks, including storage issues, electrical safety and environmental wear and tear, are now recorded on the risk register and reviewed through governance meetings. Learning from environmental findings is used to inform maintenance planning and prioritisation.

Through the immediate remediation of identified defects, the introduction of additional storage solutions, a rolling maintenance programme, routine environmental audits, risk register oversight and provider-level assurance, the Registered Provider is satisfied that the premises now meets Schedule 6 requirements and will achieve and maintain full compliance with Regulation 17.

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| Regulation 27: Infection control | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <p>The Registered Provider has taken immediate action to address the infection prevention and control failures identified at inspection and has strengthened IPC systems to ensure that potential outbreaks are detected and managed in line with national guidance. A review of the respiratory illness cases was undertaken to identify the root causes of the failure to detect and manage the potential ARI outbreak. Corrective actions have been implemented to strengthen outbreak recognition, escalation, and response processes. An Acute Respiratory Infection (ARI) outbreak management protocol will be introduced in line with HSE and Public Health guidance. This will set out thresholds for identifying outbreaks, testing requirements for influenza A and B, COVID-19 and RSV, cohorting and isolation measures, and escalation pathways, including triggers for notifying Public Health.</p> <p>An IPC surveillance system is being strengthened. Surveillance findings will be reviewed and escalated promptly where outbreak thresholds are met.</p> <p>The continence equipment washer has been serviced and brought back into compliance. A planned preventative maintenance schedule is being introduced for all IPC-related equipment.</p> <p>A monthly IPC audit programme is being introduced, and refresher training is being provided to staff on outbreak recognition, escalation and transmission-based precautions. An IPC Link Practitioner has been nominated to strengthen local oversight. Further training will be provided.</p> <p>IPC risks are recorded on the risk register and reviewed through governance meetings, with provider oversight to ensure sustained compliance with Regulation 27 and the National Standards for IPC (2018).</p> | |
| Regulation 28: Fire precautions | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>The Registered Provider has taken immediate action to address the fire safety failures identified at inspection and has strengthened fire safety systems to ensure that adequate precautions are in place to protect residents, staff and visitors.</p> <p>A call bell system will be installed in the external smoking area to ensure that residents can summon assistance immediately in the event of an emergency. Currently there are no residents who smoke at the nursing home.</p> <p>Emergency lighting has been inspected, and any defective fittings have been repaired to ensure adequate illumination of escape routes. A formal emergency lighting testing and maintenance programme has been introduced to ensure that all emergency lighting is checked routinely, and defects are identified and rectified promptly.</p> <p>Fire containment measures have been strengthened. The visible gap underneath the bedroom door on the first floor has been rectified, and the cross-corridor fire door that</p> | |

did not form an effective seal has been repaired or replaced to ensure that all fire doors provide effective fire and smoke containment.

Fire safety training and evacuation preparedness have been strengthened. The fire drill programme is being revised to ensure that drills clearly record the number of participants involved, the specific equipment used to evacuate each resident, resident dependency levels, and evacuation times. Learning from drills is recorded and used to improve emergency preparedness.

Weekly fire safety checks are being formalised, including checks of emergency lighting, fire doors and escape routes, with findings recorded in a maintenance log and overseen by the Person in Charge. Fire safety risks are recorded on the risk register and reviewed through governance meetings.

The Registered Provider Representative maintains oversight of fire safety governance through review of fire audits, drill records, risk register entries and escalation activity. Through the immediate remediation of identified fire safety defects, the planned installation of a call bell system, strengthened fire containment measures, enhanced fire drill documentation, routine fire safety checks, risk register oversight and provider-level assurance, the Registered Provider is satisfied that fire safety systems will be robust, sustainable and will achieve and maintain full compliance with Regulation 28.

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| Regulation 5: Individual assessment and care plan | Not Compliant |
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

The Registered Provider has taken immediate action to address the care planning failures identified at inspection and has strengthened assessment and care planning systems to ensure that all residents have comprehensive, accurate and up-to-date care plans that reflect their assessed needs.

A full audit of all resident assessments and care plans is currently underway to ensure that comprehensive assessments have been completed for all residents and that care plans accurately reflect residents' current clinical needs, dependency levels, responsive behaviours, supervision requirements and nutritional status. Any gaps or discrepancies identified through the audit are being rectified without delay and are tracked through an action log until fully resolved.

Care plans for residents displaying responsive behaviours have been reviewed and updated to ensure that behaviours, triggers, risks and person-centred interventions are clearly documented. Supervision plans have been reviewed and aligned with actual supervisory arrangements to ensure that care plans accurately reflect how residents are supported in practice.

Care plans are now reviewed promptly in response to any change in a resident's condition, needs or risk profile. Where nutritional assessments identify a resident as being at high risk of malnutrition, the resident's care plan is updated immediately to include appropriate nutritional interventions, monitoring requirements and referral to

dietetic services where required.

A formal four-monthly care plan review schedule is being introduced to ensure that all care plans are reviewed at regular intervals, with defined triggers for earlier review based on changes in condition, incidents, falls, weight loss, responsive behaviours or increased supervision needs.

Care planning compliance is now monitored through a monthly audit programme, with findings reviewed through governance meetings and escalated where non-compliance or risk is identified. Corrective actions arising from audits are assigned to named owners, tracked to completion and overseen by management.

Staff training and refresher guidance is being provided on comprehensive assessment, care planning standards, documentation of responsive behaviours, supervision planning and nutritional care planning.

The Registered Provider Representative maintains oversight of care planning compliance through review of audit findings, monitoring of outstanding actions and escalation of any recurring or systemic issues.

Through the completion of a full care plan audit, strengthened assessment and documentation standards, alignment of supervision plans with practice, timely updating of care plans in response to changing needs, routine audit, staff training and provider-level oversight, the Registered Provider is satisfied that assessment and care planning systems will be robust, sustainable and will achieve and maintain full compliance with Regulation 5.

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| Regulation 25: Temporary absence or discharge of residents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

The Registered Provider has taken immediate action to address failures in relation to documentation of residents’ temporary absences and has strengthened systems to ensure that all hospital transfers are recorded accurately and consistently.

The four resident records identified at inspection have been reviewed, and the missing nursing documentation relating to their hospital transfers has now been completed and placed on file.

A standardised hospital transfer checklist has been introduced to ensure that all required information accompanies residents on transfer to hospital and that a clear nursing record of the transfer is completed for every temporary absence. This includes the reason for transfer, clinical status, observations, documentation sent with the resident, and communication with family and medical practitioners.

Responsibility for completion of hospital transfer documentation has been clarified, with the nurse in charge of the shift responsible for ensuring that all required documentation

is completed and filed appropriately.

Transfer documentation is now checked for completeness when residents return to the centre, and any gaps are corrected without delay.

The Registered Provider Representative maintains oversight of compliance through review of any recurring or systemic issues raised through governance.

Through the completion of outstanding documentation, the introduction of a standardised transfer checklist, clarified accountability, staff guidance and provider oversight, the Registered Provider is satisfied that systems are now robust and will achieve and maintain full compliance with Regulation 25

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 |
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| Regulation 15(1) | The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned. | Not Compliant | Orange | 31/10/2025 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Substantially Compliant | Yellow | 31/12/2026 |
| Regulation 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre | Substantially Compliant | Yellow | 15/11/2025 |

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| | and are available for inspection by the Chief Inspector. | | | |
| Regulation 23(1)(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. | Not Compliant | Red | 31/10/2025 |
| Regulation 23(1)(b) | The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. | Not Compliant | Red | 31/10/2025 |
| Regulation 23(1)(d) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 12/01/2026 |
| Regulation 23(1)(e) | The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to | Not Compliant | Orange | 15/02/2026 |

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| | residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act. | | | |
| Regulation 24(1) | The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre. | Substantially Compliant | Yellow | 15/11/2025 |
| Regulation 25(1) | When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant | Not Compliant | Orange | 31/10/2025 |

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| | information about the resident is provided to the receiving designated centre, hospital or place. | | | |
| Regulation 27(a) | The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff. | Not Compliant | Orange | 01/12/2025 |
| 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. | Substantially Compliant | Yellow | 30/11/2025 |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Substantially Compliant | Yellow | 30/11/2025 |
| Regulation 28(1)(e) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre | Not Compliant | Orange | 30/11/2025 |

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| | and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | | | |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Substantially Compliant | Yellow | 30/11/2025 |
| 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 | 31/10/2025 |
| Regulation 5(1) | The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2). | Not Compliant | Orange | 30/11/2025 |
| Regulation 5(2) | The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a | Substantially Compliant | Yellow | 31/10/2025 |

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| | person who intends to be a resident immediately before or on the person's admission to a designated centre. | | | |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | Not Compliant | Orange | 31/12/2025 |