



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

Issued by the Chief Inspector

Name of designated centre:	St Joseph's Care Centre
Name of provider:	Health Service Executive
Address of centre:	Dublin Road, Longford, Longford
Type of inspection:	Unannounced
Date of inspection:	25 November 2025
Centre ID:	OSV-0000466
Fieldwork ID:	MON-0048805

About the designated centre

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

St Joseph's Care Centre provides 24-hour nursing care for up to 65 residents of all dependency levels, male and female, predominantly over 65 years of age. The centre can provide care to a range of needs of various complexity, including dementia care and cognitive impairment, acquired brain injury, palliative and palliative respite care. The centre is single-storey and comprises of two buildings containing five units. There are communal rooms and internal gardens available to residents as well as a large chapel. The centre's philosophy and motto is to 'add life to years when you cannot add years to life' and aims to address the physical, emotional, social and spiritual needs of all residents with a holistic approach of empathy and kindness. The centre is located in Longford town within easy reach of nearby shops and restaurants. Parking facilities are available on site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49
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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
Tuesday 25 November 2025	08:00hrs to 16:30hrs	Catherine Connolly-Gargan	Lead
Tuesday 25 November 2025	08:00hrs to 16:30hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

This unannounced inspection was completed over one day by two inspectors of social services. Overall, the inspectors found that residents were satisfied with the standards of care and the supports they received to meet their needs, and were mostly positive in their feedback regarding the quality of their lives in the centre. Residents said that they felt safe and were comfortable living in the centre, and the inspectors observed that residents clearly valued and trusted the staff team caring for them. Staff took time to talk with residents during their care delivery, and the inspectors observed that residents responded positively to these interactions. Staff interactions with residents throughout the day were warm, kind and person-centred.

On arrival, the inspectors were met by the person deputising for the person in charge, and after a short introductory meeting, the inspectors completed a walk around all areas of the centre premises. This gave the inspectors the opportunity to meet with residents and night and day staff, observe staff practices and interactions with the residents, and to get an insight into the residents' experiences of living in the designated centre. The inspectors observed that while many of the residents were still sleeping, other residents were awake and were either independently or with the assistance of staff preparing for the day.

Residents who spoke with the inspectors commented that they were "happy living here", "I am well minded", and "I want for nothing". One resident particularly valued staff being nearby if they felt unwell or needed some assistance. Residents in Our Lady's Unit 1 (OLU 1) expressed a high level of satisfaction with the opportunities they now had to participate in social activities that they enjoyed. One of the residents in this unit told the inspectors that they 'look forward to each day'. While the staff and the person deputising for the person in charge discussed their plans to implement the social activity programme model in this unit to enhance the residents' quality of life in the other three units, implementation was at an early stage. This information concurred with the inspectors' observations on the day regarding a number of the residents in Padre Pio, Sunset Lodge and Autumn Lodge units who did not have adequate opportunities provided to them to participate in social activities in line with preferences and capacities. These observations were particularly evident regarding residents' experiences in the Sunset and Autumn Lodge units.

Residents again, on this inspection, had mixed views on the quality of their social care provision in the centre. Aside from the weekly live music sessions, the inspectors observed that there was a high dependence on television viewing, family visits and chats with other residents in Padre Pio, Sunset Lodge and Autumn Lodge units. The residents' sitting room in Autumn Lodge was not available as works were in progress to replace the window, and the sitting room environment in the Sunset Lodge unit was very warm, and a number of residents were asleep in their chairs.

On the day of the inspection, a scheduled live music session was facilitated in the afternoon for the residents by a local musician. This live music session was very popular with the residents, and most of the residents participated. Residents told the inspector that they particularly enjoyed this weekly music event. Two residents said they looked forward to it all week. Another resident said that they "absolutely loved listening and singing along". The inspectors observed that there was a fun and lively atmosphere as the musician sang the residents' favourite songs, and the residents, together with the staff sang along with him.

Residents' bedroom accommodation was arranged on the ground floor level throughout in four separate units. Sunset and Autumn Lodge units were located in a separate building on an elevated site at the back of the main building. Padre Pio and Our Lady's Unit 1 were located in the main building. The Lodge units were accessible via steps and a pedestrian sloped walkway, which had handrails fitted on either side to support safe access for the residents and others.

The layout of residents' bedrooms, with the exception of five twin-occupancy bedrooms numbered 2, 4, 8, 9 and 11 in the Sunset Lodge unit, generally met their needs. The layout of these five bedrooms and the limited circulation space available around one resident's bed in each of these rooms did not meet residents' needs. A number of residents in these bedrooms needed assistive equipment, including high support wheelchairs, and the limited circulation space and layout of these bedrooms did not support safe manoeuvring of these chairs or allow residents to sit in a chair by their bedside if they wished. Additionally, the layout of these bedrooms did not support residents using mobility aids to safely move around their bed space and to access their personal belongings. Residents' rights to privacy could also not be assured during transfer and personal care activities. The inspectors observed that many of the residents chose and were supported by staff and their families to personalise their bed spaces with their photographs and other personal items that were important to them.

The communal dining rooms and sitting rooms were mostly bright, spacious and well-decorated with traditional furnishings and memorabilia that were familiar to the residents. Residents were well supported by staff during mealtimes. The dining room located in the Sunset Lodge unit was shared by 15 residents in this unit. However, this room did not have sufficient dining furniture or space to accommodate all 15 residents in one sitting. In the absence of any clear arrangement to support all residents to dine in the dining room if they wished, the inspectors observed that due to space limitations, only eight residents dined in the dining room during the lunchtime meal, five of whom were seated at the two dining tables available and three other residents were seated in high support chairs, and were served their meals on small mobile tables placed in front of their wheelchairs. The remaining residents dined either where they were seated in the sitting room in the Sunset lodge unit or in their bedrooms.

The inspectors observed that work was in progress on the day of the inspection in an area that was closed off to the side of the main reception and in an area of the premises that was not part of the designated centre. Our Lady's Unit 2 was not in use and was secured off from the rest of the designated centre. The areas of the

centre where works were in progress were secured and were not accessible to residents or others to ensure their safety. Overall, the general environment and residents' bedrooms, communal areas, toilets and bathrooms in the designated centre were observed to be visibly clean and mostly well-maintained. However, the inspectors observed that a storeroom located off the main reception area was in need of maintenance and cleaning. The inspectors saw that one area of the ceiling in this storeroom was separating from the wall and appeared to be unsecure. Paint was bubbling and missing on parts of the walls, and large amounts of dust and a black mould-like material were visible on two walls. This room was observed by the inspectors to be in use for the storage of both clinical and non-clinical supplies.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This inspection found that the management and oversight of the service had improved since the last inspection to ensure residents were appropriately safeguarded and that their care was effective. Notwithstanding these improvements, action and resources were necessary to ensure that residents were adequately protected from risk of fire, that residents' social care needs were adequately met, and that the twin-occupancy bedrooms and the dining room in Sunset Lodge unit met residents' needs in line with the designated centre's statement of purpose.

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on the actions the provider committed to in their compliance plan to address significant non-compliance with the regulations as identified during the last inspection carried out in July 2025.

The provider submitted an application to vary Conditions 1 and 3 on the designated centre's registration. This application was to change the purpose of a number of areas and to register a part of the premises not currently registered for residents' use, and to remove Our Lady's unit 2 as part of the designated centre. These proposed changes were to facilitate the next phase of building a new centre premises on the campus. This application was assessed by the inspectors as part of this inspection. However, due to building and fire safety works not being progressed at the time of this inspection, this application was not able to be fully assessed by the inspectors as part of this inspection.

The registered provider of St Joseph's Care Centre is the Health Service Executive (HSE). The provider is represented by a general service manager. The local management team consisted of a person in charge (PIC) who was appointed by the provider in May 2025 to deputise during unplanned leave. An assistant director of

nursing (ADON) position was vacant since October 2025, and had not been replaced at the time of this inspection. Therefore, this inspection found again that the management structure in place did not reflect the centre's statement of purpose.

The local management team were supported by a team of staff nurses, healthcare assistants, activity staff, cleaning, catering and administration staff. A regional manager of older person's services had oversight responsibility for this designated centre and provided support to the centre's local management team. As a national provider involved in operating residential services for older people, this designated centre benefits from access to and support from centralised departments such as human resources, information technology, practice development, staff training and finance.

The inspectors reviewed the work staff rosters and observed staff practices during the day, and were not assured that the system of staff allocation in Sunset and Autumn Lodge Units ensured adequate supervision and delivery of quality and safe care to residents. The provider had recruited nursing and healthcare assistant staff since the last inspection, and as a result, fewer agency staff were contracted to replace nursing and healthcare staff vacancies ensuring continuity of care for residents.

The staff training records showed that staff had access to mandatory and professional development training, including attendance at further training in safeguarding residents from abuse, and in responding to and managing residents' responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), since the last inspection.

Notwithstanding the improvements made, staff supervision in their roles to ensure residents were provided with adequate opportunities to participate in a social activity programme in line with their preferences and capacities was found to be necessary again on this inspection. The inspectors' findings are discussed further under Regulation 16: Training and staff development.

The provider had arrangements in place for recording accidents and any incidents, including safeguarding incidents involving residents in the centre, and for appropriately notifying the office of the Chief Inspector of Social Services as required by the regulations. Records that must be maintained in the designated centre were held securely and were made available to the inspectors.

Regulation 14: Persons in charge

The person in charge was on statutory leave at the time of this inspection and suitable deputising arrangements were in place.

Judgment: Compliant

Regulation 15: Staffing

The system of staff allocation in the Sunset Lodge Unit did not ensure that there was sufficient staff with appropriate skills available to meet residents' needs. The inspectors found the following:

- Staff did not consistently remain with residents in the communal sitting room in Sunset Lodge unit, and were therefore not available to respond to residents' needs for assistance as necessary.
- With the exception of Our Lady's Unit, allocation of staff in the other three units did not ensure that staff were available to support residents with adequate opportunities to participate in social activities in line with their preferences.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised according to their roles to ensure that they carried out their work to the required standards. As there was ineffective staff allocation at unit levels, supervision of staff was not adequate:

- Staff did not ensure that residents were provided with opportunities to participate in a meaningful social activity programme that met their interests and was in line with their capacities, which impacted on their quality of life in the centre.

This finding is repeated from the previous inspections.

Judgment: Substantially compliant

Regulation 21: Records

Although information was available that one staff member working in the centre had vetting procedures completed, a vetting disclosure in accordance with National Vetting Bureau (Children and Vulnerable Adults) legislation was not available in this staff member's file.

Judgment: Not compliant

Regulation 23: Governance and management

The management structure in place was not clearly defined with clear lines of accountability and responsibility, as the provider had not ensured that the local management structure was maintained in line with the centre's statement of purpose. An assistant director of nursing position was vacant since October 2025. This impacted on effective governance and oversight of the service and suitable deputising arrangements were not available in the event of an absence by the person in charge.

The governance and management systems in place did not adequately ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored regarding the following findings on this inspection. The registered provider failed to recognise and address the following findings;

- The accessibility, storage and right to privacy and dignity needs of residents accommodated in five twin-occupancy bedrooms in Sunset Lodge Unit were not being met. This inspection found that residents' accessibility, access to their personal possessions and rights to privacy and dignity in these bedrooms were negatively impacted and were not in accordance with the provider's statement of purpose. The inspectors' findings are discussed further under Regulation 9: Residents' Rights, Regulation 12: personal Possessions and Regulation 17: Premises.
- The provider had not ensured that residents had opportunity to participate in meaningful social activities to meet their needs. This is discussed under Regulation 9: Residents' Rights.

The provider's management of risk in the centre was not effective, and as a result, the systems in place to identify, manage and respond to risk and ensure residents' safety were not adequate. This was evidenced by the following:

- The provider had not recognised some of the fire risks found on the inspection and additional fire precautions were required to ensure that residents were protected from the risk of fire as detailed under regulation 28: Fire Precautions.
- On the day and subsequent to the inspection, assurances were requested and submitted by the provider in order to safeguard the safety and wellbeing of service users. This was in regards to significant non-compliances of fire containment measures identified in a Communications Room. The provider committed to addressing this fire risk in a timely fashion. This is detailed under regulation 28: Fire Precautions.
- The provider had not addressed extensive works to the electrical system which had been identified throughout the designated centre on July 2025. Improvements were required to the maintenance of fire doors, containment

measures and the building fabric. These and additional risks are outlined in detail under regulation 28: Fire Precautions.

- The premises was not adequately maintained and posed a risk to residents' safety. A storeroom used for storage of clinical and non-clinical supplies was in a state of disrepair and posed a risk to residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. Notifications and quarterly reports were submitted as required and within the time frames as specified by the regulations. Unplanned absence by the person in charge and the details of the deputising arrangement during the person in charge's absence were notified to the Chief inspector as required.

Judgment: Compliant

Quality and safety

Overall, residents were provided with satisfactory standards of nursing care and supports, including residents who experienced responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). This had positive outcomes for these residents' wellbeing and safety. However, this inspection found that the social care needs were not adequately met for a number of residents in three of the four units in the centre. Furthermore, residents' rights were negatively impacted by the layout of five twin-occupancy bedrooms in the Sunset and Autumn Lodge units. Additionally, due to the layout and provision of insufficient dining room furniture, the residents in these two units were also not adequately supported to dine in the dining room, as they wished, and in line with the designated centre's statement of purpose.

Residents had timely access to healthcare and multidisciplinary professional expertise to meet their needs. This inspection found that staff provided appropriate support and care for those residents who were known to experience responsive behaviours. This had positive outcomes for all residents' wellbeing and safety.

On review of residents' care documentation, this inspection found that residents' needs were comprehensively assessed and their care plans and care records were mostly up-to-date to guide staff on their care of residents. Although many of the residents' social care assessments were improved on this inspection, not all

residents' assessments were reflected in social care plans in line with each their personal interests, capacities and preferences. As a result, residents' social care plans were not effectively informing the opportunities provided to many of the residents to ensure participate in meaningful social activities. This finding is repeated from the last two inspections and continued to pose a risk that not all residents' social care needs would be effectively communicated to all staff and be effectively met.

All the residents' accommodation was provided on the ground floor level in the designated centre. Residents' living environment was generally well maintained, and was decorated in a traditional style that was familiar to them. While the layout of most of the residents' bedrooms met their needs, the layout of five twin-occupancy bedrooms and the dining room in Sunset Lodge Unit did not meet residents' needs in line with the designated centre's statement of purpose. Ongoing maintenance arrangements were also not ensuring that the necessary painting and repair of surfaces in a store room were completed in a timely manner. The inspectors' findings are discussed further under Regulation 9: Residents' Rights, Regulation 12: Personal possessions and Regulation 17: Premises.

Measures were in place to protect residents from the risk of abuse. Residents confirmed that they felt safe and secure living in the centre.

Residents had access to local and national newspapers and radios. Residents had access to religious services and were supported to practice their religious faiths in the centre. Residents' meetings were convened, and issues raised by residents as areas needing improvement were addressed. Residents had access to local and national newspapers and radios.

This inspection found that the management of fire safety, as described in Regulation 23: Governance and Management section of this report, did not fully ensure the safety of residents, staff and visitors.

The inspectors found non-compliance over fire-containment, visual deficiencies in the building fabric and fire doors. Improvements were required for evacuation procedures and fire precautions. Other concerns were identified in regards to the current and proposed re-purposing of rooms that required a review by the providers' competent fire person.

Due to the previous works carried out in regards to rooms that have been re-purposed and the proposed works, an updated fire safety risk assessment is required to ensure the Chief Inspector that the provider will come into compliance with Regulation 28: Fire Precautions. Furthermore, extensive works to the electrical system had been identified throughout the designated centre in July 2025. However, these risks remained unresolved at the time of this inspection and were not addressed in a timely fashion by the provider. These and additional fire safety risks are detailed under Regulation 28: Fire Precautions.

The inspectors reviewed the fire safety register and noted that parts of it were well organised. In-house periodic fire safety checks were being completed and logged in the register as required. However, deficiencies identified such as in fire precautions

and deficiencies in the building fabric, containment had not been identified in the in-house routine checks.

Staff were knowledgeable on the evacuation strategy in the centre. Personal emergency evacuation plans (PEEP) were in place for residents. The individual residents' PEEPs contained pertinent information to inform the evacuation of the resident. However, evacuation times to evacuate the largest fire compartment in one unit were excessive. As a result, additional fire training is required for staff to receive further aid and support in regards to this.

Fire evacuation plans were displayed throughout the centre. When checked, the fire alarm panel was functional and free of fault. Escape corridors were kept clear and ready for evacuation. Most of the Fire exits were clear and available. However, an existing fire exit from a corridor was observed to be blocked up. Assurances are required that this change to a means of escape has been risk assessed.

Service records were available for the fire detection alarm system, and the emergency lighting system services, and these were all up-to-date.

Regulation 12: Personal possessions

Due to the layout and limited circulation space around the residents' beds in the twin occupancy bedrooms numbered 2, 4, 8, 9 and 11, residents using assistive equipment could not access their wardrobes or personal possessions in Sunset Lodge Unit.

One resident's bedside locker was located on the other side of the room and therefore could not be accessed by the resident when resting in bed, in bedroom number 11 in Sunset Lodge Unit.

There was insufficient storage available to meet the personal storage needs of one resident in a twin-occupancy bedroom number 8 in Sunset Lodge unit.

Judgment: Substantially compliant

Regulation 17: Premises

The provider had not ensured that the layout of five twin-occupancy bedrooms numbered 2, 4, 8, 9 and 11 in Sunset Lodge Unit conformed to the matters set out in Schedule 6 of the regulations and met the needs of residents in accordance with the centre's statement of purpose. This was evidenced by the following findings;

- There was limited circulation space available around one resident's bed in twin-occupancy bedrooms numbered 2, 4, 8, 9 and 11 in Sunset Lodge Unit

due to the design and layout of these bedrooms. The circulation space available around each resident's bed was limited and negatively impacted on their access. A number of residents accommodated in these bedrooms used high-support wheelchairs and mobility aids to support their needs. This meant that these residents' bed spaces were not laid out in a way that facilitated residents with assistive equipment to safely manoeuvre around their beds and to rest in a comfortable chair by their bedside.

- There was insufficient space available and the amount of dining room furniture available in the dining room in Sunset Lodge was not sufficient. This dining room was also provided to meet the needs of the residents in the Autumn Lodge unit, which meant that this was the only dining room facility available for 24 residents.
- A storeroom off the main reception area of the centre was not adequately maintained. The inspectors observed that the ceiling was in significant disrepair, and paint was bubbling, chipped and missing on parts of the wall surfaces. There was visible dust and black mould-like material on parts of the wall surfaces.
- There were some areas where walls and ceiling surfaces were visibly damaged or had holes that required sealing and redecoration to address gaps in these surfaces.
- Some doors sampled required repair due to damage, wear and tear.
- A casing for an emergency light was missing from a room.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre required improvement to provide adequate precautions against the risk of fire. For example:

- A designated smoking area not provided with appropriate fire precautions: For example, a fire blanket, a fire extinguisher and a fully equipped first aid kit, to include burn gel were missing from this area.

Arrangements for the maintenance of the means of escape, building fabric and building services were not fully implemented.

- An existing fire exit from a corridor was observed to be blocked up. A manual call point and a green break- glass unit remained in place. Assurances are required that this change to a means of escape has been risk assessed.

- A compartment cross-corridor door was noted to have caps that would allow smoke and fire to enter the adjoining area, and a ceiling was observed to be failing and falling down in a store room.
- Georgian glazing was identified in residents' bedrooms along a means of escape, a linen room and a store room that overlooked a corridor. A sliding vision panel was also noted in a linen room adjacent to a bathroom. This type of glazing appeared to not provide the required fire resistance.
- Some areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures. A Clerical Office room and an electrical storage cabinet in a nurse's station were identified with penetrations and holes through the fire rated ceiling. Fire containment breaches were identified in the assembly hall through the ceiling area that required fire sealing.
- Furthermore, fire containment breaches were identified in a communications rooms, the corridor outside the communications room and into the adjoining unit of Padre Pio. Numerous wiring and cabling were observed traversing unsupported from the communications room, across the corridor and through the adjoining unit of Padre Pio. Holes and gaps were noted around these areas that required fire sealing.
- From a review of electrical reports and maintenance reports, extensive works to the electrical system had been identified throughout the designated centre in July 2025. Most risks identified were required to be rectified within 30 to 90 days. However, these risks remained unresolved at the time of this inspection. As such, the inspectors could not be assured that the electrical system was being appropriately maintained and risks were being addressed within a timely fashion.

The provider needed to adequately review fire precautions throughout the centre. For example:

- Several rooms in the designated centre are proposed to be repurposed. These included a chapel to a meeting room, two sacristies to offices, a large chapel to a physiotherapy room and a toilet facility was now in use as a hairdresser room. The inspectors noted fire doors were missing from these rooms. These and other examples of rooms that are proposed or had been repurposed were identified throughout the centre.
- A fire risk assessment was not available in relation to rooms where the function of each room had changed within the registered designed centre or is proposed to be changed. This required a review by the providers' competent fire person.
- Due to the previous works carried out in regards to rooms that have been repurposed and the proposed works, an updated fire safety risk assessment is required to ensure the Chief Inspector that the provider will be in compliance with Regulation 28: Fire Precautions and the fire safety certificate for the building.

Arrangements required improvement to ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre

and in so far as is reasonably practicable, residents, were aware of the procedure to be followed in the case of a fire. For example:

- While simulated evacuation drills were taking place, the inspectors were not assured, based on the drills reviewed, that staff in Our Lady's Unit One were adequately prepared for the scenarios that are likely to be encountered by them in the event of a fire in the centre. The inspectors considered the recorded evacuation times to evacuate the largest fire compartment in this unit to be excessive. As a result, additional fire training is required for staff to receive further aid and support in regards to this.

The registered provider did not make adequate arrangements for containing fires. For example:

- Fire doors were not provided to some rooms or were damaged. An ADON's office was not fitted with a fire door or a door closing mechanism. A ceiling hatch appeared to not provide the required fire resistance. A DSR room was in use as a cleaner's store. However, this room was not fitted with a fire door. FD60s cross-corridor doors into Padre Pio Unit were observed with gaps at the top of the surrounding frame, and a vision panel frame was damaged.
- Two toilet rooms located off the main lobby/seating area had been repurposed as an oxygen store room 1 and a photocopying room. A ventilation shaft was noted in the oxygen room that extended into a protected corridor and extended through the corridor ceiling. Ventilation ducting can allow the movement of smoke, fumes and fire from one area to another, should either be fire resisting or contained within fire-resisting construction and should not be capable of spreading fire, smoke or harmful gases throughout the centre. Therefore, assurances are required that the ventilation ducting will prevent the spread of smoke, fumes or fire to adjoining areas. This required a review by the providers' competent fire person.
- A large service ducting traversed several rooms and the Padre Pio Unit. In an adjoining toilet, the service ducting was exposed, and the inspector could not be assured the material used to encase the ducting met the required fire resistance and would prevent the spread of smoke, fumes or fire to adjoining areas.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Although residents' documentation was improved on this inspection, some residents' care plans continued to require further detail to ensure that their care documentation clearly guided staff on their care needs. For example;

- A disconnection was found again on this inspection between the assessments of some residents' social care needs and the information in their care plans describing the social activities available to them to meet their interests and capacities. As a result, these residents' social care plans did not describe a social activity programme tailored to meet their individual interests and capacities. Furthermore, many of the records of the social activities that residents participated in did not reference that residents were provided with opportunities to participate in the social activities that they preferred and were described in their care plans.
- Two residents' nutrition care plans were not updated with a number of the recommendations made following review of their needs by the speech and language therapy specialist.
- The fluid intake needs of one resident who depended fully on staff to support them with meeting their hydration needs were not detailed in this resident's care plan. In addition, information was not available in this resident's care documentation to guide staff on the actions they should take if this resident's intake needs were not being met. This posed a risk that this pertinent information would not be clearly communicated to all staff caring for this resident.

These findings are repeated from the last inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' nursing and healthcare needs were met to the required professional standards, and residents had timely access to their GPs. An on-call GP service located on the campus was available to residents out-of-hours as needed.

Residents were appropriately referred to health and social care professionals, specialist medical and nursing services, including psychiatry of older age, community palliative care and tissue viability specialists as needed.

Residents were supported to safely attend out-patient and other appointments to meet their ongoing healthcare needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a positive and supportive approach evident on this inspection in how residents who were predisposed to experiencing episodes of responsive behaviours

(how persons with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were cared for by staff. This improved care and support was clearly demonstrated in positive outcomes in these residents' wellbeing, safety and quality of life. Staff were facilitated to attend recent training to ensure they had up-to-date knowledge and skills in meeting the support and care needs of residents who experienced responsive behaviours.

Judgment: Compliant

Regulation 8: Protection

The centre had policies and procedures in place to protect residents from abuse. The provider ensured that staff were facilitated to attend refresher training on safeguarding residents from abuse since the last inspection. Staff were aware of the reporting procedures and of their responsibility to report any concerns they may have regarding residents' safety in the centre. Residents told the inspectors that they felt safe in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

With the exception of residents on Our Lady's Unit (OLU 1), the provider had not ensured that residents were provided with adequate opportunities to participate in meaningful social activities in line with their interests, preferences and capacities. For example:

- The inspectors observed again on this inspection that the social activity programme for residents was limited, particularly in the Sunset and Autumn Lodge units, and was available for a small number of residents only. The inspectors found that many of the residents sitting in the sitting room and in their bedrooms on the day of the inspection were not adequately supported to participate in meaningful social activities to meet their interests and capabilities. There was a high reliance on television viewing in the sitting room. This observation was supported by feedback from a number of residents again on this inspection, who said that they did not participate in social activities. Documentation available regarding the social activities each resident participated in and engaged in to meet their needs was also limited. The inspectors found that the types of activities that individual residents participated in were not frequently documented, and often not meaningful. There were also many gaps in the records available, where no activities were documented for many of the residents for a number of days, and they did not

reference that residents were offered alternative activities when they chose not to participate in the available options.

Residents' rights to privacy in their bedrooms during personal care and transfer procedures could not be respected due to the layout and circulation space available in five twin occupancy bedrooms. Due to the limited space available around a number of the residents' beds in these twin-occupancy bedrooms, residents could not choose to sit in a chair by their bedside if they wished.

Due to the unavailability of adequate dining room arrangements in Sunset and Autumn Lodge units, residents could not exercise choice in their daily dining routines.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Joseph's Care Centre OSV-0000466

Inspection ID: MON-0048805

Date of inspection: 25/11/2025

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	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: The staff level, skill mix and deployment of staff in the centre has been reviewed. A CNM is delegated to ensure supervision by staff assigned to the dayrooms in each unit to support residents during the day.</p> <p>The Lodge is considered as one unit with 2 sub corridors and as one unit staff will move between corridors to support supervision requirements between Autumn and Sunset.</p> <p>The activity program has been reviewed and has been piloted on OLU 1, it is currently being rolled out on the other 2 units. Each residents' Pool Activity Level (PAL) has been reassessed to inform activity care plans ensuring that activities are based on will and preference of the residents in line with capability.</p> <p>The activity roster has been reviewed and the proposed weekly activity programs are submitted to nursing admin for approval and sign off.</p> <p>Each day a group activity is organized and there is availability of activity staff members to perform one to one activities in accordance with residents' care plans, in line with residents capabilities, capacity and interests in addition to group activities.</p> <p>A new engagement tool has been developed to record and document residents' participation in activities. This will be reviewed and monitored and if residents decline the records will detail alternative options offered.</p>	

Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The staffing levels, skill mix and deployment of staff in the Unit has been reviewed. CNM's on each unit have commenced PDP's and appraisals for Nurses and HCA's in each unit following which training needs analysis will be developed to address any shortfalls in training and skills development.</p> <p>All staff have participated in person centred care training delivered in 2025. CNM's in each unit provide direction, supervision and feedback to staff to ensure it is being implemented.</p> <p>Each residents Pool Activity Level (PAL) has been reassessed to inform activity care plans ensuring that activities are based on will and preference of the resident in line with capability and assessed preferences.</p> <p>The proposed weekly planner to accommodate groups and 1:1 activities is submitted to Nursing Admin for review and sign off each week now. CNM in Nursing Admin has been delegated oversight of activity staff roster and activity planning and the CNM's in each unit are allocated responsibility to ensure the activity roster is implemented.</p> <p>Roll out of revised activity programme and engagement tool has been completed in OLU 1 and is currently being rolled out in the other units supported by the clinical facilitator.</p> <p>In Q3 2026, a new quality initiative will be introduced to the Centre by the OT who will support staff in its implementation. This Multidisciplinary team initiative aims to deliver person-centred sensory modulation programs to residents with dementia which will further enhance the activation of more dependent residents and support improved socialisation and engagement for residents who prefer one to one sensory based activities.</p> <p>]</p>	
Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <p>The Garda Vetting Disclosure for the staff member is available in the staff member's personnel file.</p> <p>All Vetting disclosures have been rechecked to confirm they are in place for each staff member and these are rearranged now into their individual staff files.</p> <p>]</p>	

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 fire precautions have been reviewed throughout the Centre to include the arrangements for maintenance, day-to-day operations and the procedures for containing fires.</p> <p>The assistant director of nursing post was filled in May 2025 and was deputising in absence of PIC at time of inspection in Nov 2025. The DON/PIC subsequently resigned in Dec 2025 and a PIC has been appointed. There is long term 0.5 CNM 2 post appointment supporting PIC in Nursing Admin.</p> <p>There is currently a campaign for Director of Nursing/PIC in progress which will result in the appointment of a permanent DON and ADON.</p> <p>Each Unit has CNM providing oversight and supervision to staff in the units. An additional CNM has been appointed and is due to take up their post on March 9th 2026 to further support governance on each unit.</p> <p>The PIC undertakes daily walk arounds on each of the units to speak with residents, visitors and staff as well as convening monthly meetings with CNM's to ensure safe care, appropriate and consistent service is being provided to residents.</p> <p>The configuration of the twin bedrooms has been reviewed to ensure access to wardrobes and personal space. High support equipment is no longer stored within the resident's bedroom and each resident is risk assessed to ensure their suitably, taking account of their dependency level, within a twin bedroom.</p> <p>Privacy screens are provided at each bed area to provide privacy for residents when attending to personal care and transfers.</p> <p>CNM's have been delegated to ensure that arrangements are in place to ensure supervision of residents in communal rooms.</p> <p>Each residents Pool Activity Level (PAL) has been reassessed to inform activity care plan ensuring that activities are based on will and preference of the resident in line with capability.</p> <p>The activity roster has been reviewed and weekly activity programs are submitted to nursing admin for review and sign off.</p> <p>Each day a group activity is organized and there is availability of activity staff members to perform one to one activities in accordance with residents' care plans and in line with residents capabilities, capacity and interests.</p> <p>In Q3 2026 new quality initiative will be introduced to the Centre by the OT who will support staff in its implementation. This Multidisciplinary team initiative aims to deliver person-centred sensory modulation programs to residents with dementia.</p> <p>A new engagement tool has been developed to record and document residents' participation in activities and roll out of the tool is near completion supported by the clinical facilitator.</p>	

'The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.'

Regulation 12: Personal possessions

Substantially Compliant

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

On the day of inspection structural works were being finalised with the replacement of windows in the bedrooms. Each of the five twin bedrooms are fitted with an overhead tracker hoist to meet the moving and handling needs of residents and avoid the need for any additional moving aids in the room.

Each resident is risk assessed to ensure their suitably, taking account of their dependency level, within a twin bedroom.

The configuration of the bedrooms has been reviewed to ensure access to wardrobes and personal space. High support equipment is no longer stored within the resident's bedroom. A separate area has been identified for storage when not in use.

The bedside locker has been relocated adjacent to the resident bed in bedroom 11.

Regulation 17: Premises

Not Compliant

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

There are two dining rooms available in the Lodge, one in Sunset which can accommodate the fifteen residents and one Autumn which can accommodate the nine residents dining in this area.

'Able tables' have been ordered to accommodate residents in high support chairs/wheelchairs in their choice to eat in dining rooms. These tables have a higher height setting and facilitate high support wheelchairs sit close up to the table.

The store room off reception has been decanted and is no longer holding any clinical equipment. A planned upgrade for this room has been agreed with estates and is on the Centre's risk register.

In the interim, areas where walls and ceiling surfaces were damaged or had holes have been sealed to ensure the Centre is maintained in a good state of repair.

The casing on the emergency lighting has been replaced.

Doors which were damaged have been reviewed and adjusted to ensure the doors are fitting correctly.

The configuration of the bedrooms has been reviewed to ensure access to wardrobes and personal space and circulation space around beds to meet the needs of residents accommodated.

Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: The fire precautions have been reviewed throughout the centre to include the arrangements for the maintenance, day-to-day operations and the procedures for containing fires.</p> <p>The fire exit blocked is no longer an escape route. This fire exit route has been blocked in order to allow works progress to the new 43 bed extension. This route led to the Therese's' unit which has now been demolished, and other ancillary rooms which are not in use. The route has been blocked with fire rated construction and was reviewed by the fire consultant for the extension works who confirmed there was adequate escape routes from the kitchen still in place.</p> <p>Remedial works were carried out to the cross corridor doors that was noted to have gaps by maintenance following identification of this issue. Maintenance team carry out periodic repairs to doors on an ongoing basis.</p> <p>The sub compartments can be safely evacuated within the 2.5 minute timeframe A full compartment evacuation can be completed in 4 minutes 20 seconds. A number of fire drill practices have been completed at night and are on-going in the Unit to ensure all residents can be safely evacuated in the required time in line with the FRA and the current identified controls of 2.5 mins to evacuate a sub compartment.</p> <p>Fire stopping repairs was carried out to penetration at Padre Pio. Fire stopping has been installed to penetrations within the electrical cabinet. Fire rated enclosure was provided to electrical cabinet as part of previous fire upgrade works.</p> <p>Remedial fire stopping works within the assembly hall will be carried out by the 13th March</p> <p>It was agreed with the Fire Engineer to block up door D128 / CF26, which was not fire rated as required and build a fire rated shaft wall between the comms room / corridor and the store room on the store room side, as the existing wall was not fire rate construction and form a new door between the store room and Padre Pio corridor. This resulted in the comms room and corridor being treated as a single room contained by fire rated construction and removed the requirement for fire rated construction for the wall containing D129 / CF 25.</p> <p>Estates reviewed the Comms room on site following the HIQA inspection. These penetrations have now been fire stopped.</p> <p>Arrangements are being made for completion of works to the electrical system. These works will be completed within the next 2 months (30th of April)</p> <p>The repurposed rooms will not fall within the area of the designated centre based on the application to vary submitted and these areas will not be accessed by residents. Where rooms are being repurposed they will comply with the works required as per the fire safety review and fire safety certification and fire doors on repurposed rooms will meet the requirements of the Fire Safety Cert.</p> <p>A fire risk assessment was carried out by an appointed fire consultant to the physio/OT areas prior to re-purposing of these areas for use by residents. A report was issued identifying deficiencies with fire doors, fire stopping, etc. within the area. These works are now complete and have been signed off by the fire consultant. (report and sign off available if required).</p> <p>As per the Fire Cert, the door to the ADON office is not designated as a fire door. Where fire rating was required and walls did not continue to roof level, fire rated ceiling</p>	

hatches were installed to maintain integrity of the ceiling.
 The Door to store room beside ramp will be upgraded to a fire door. Remedial works were carried out to this door by maintenance following identification of this issue. Maintenance team carry out periodic repairs to doors on an ongoing basis.
 A Fire collar has been installed to the ventilation ducting in the repurposed oxygen store and photocopying room which will prevent the spread of smoke, fumes or fire to adjoining areas.
 Fire stopping has been installed where a large service duct penetrates into the Padre Pio ward.
 All staff are trained in fire evacuation procedures in line with the policy of the Centre. There is an ongoing program of renewal fire training in place. Monthly simulated evacuation drills based on a variety of scenarios are continuing in the largest fire compartment to ensure staff are skilled to evacuate all residents in a timely manner. The drills evidence the time required to evacuate residents continues to decrease mitigating risk.
 The designated smoking area has been provided with appropriate fire precautions: to include, a fire blanket. A fire extinguisher is located inside the exit door from the building to the smoking area which is in close proximity.

'The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.']

Regulation 5: Individual assessment and care plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
 Each residents Pool Activity Level (PAL) has been reassessed to inform activity care plan ensuring that activities are based on will and preference of the resident in line with capability, interest and preferences
 The activity roster has been reviewed and weekly activity programs are submitted to nursing admin for review and sign off.
 Each day a group activity is organized and there is availability of activity staff member to perform one to one activities in accordance with residents' care plans and in line with residents capabilities, capacity and interest. All residents are supported by the staff on each Unit to attend group activities organized.
 In Q3 2026 new quality initiative will be introduced to the Centre by the OT who will support staff in its implementation. This Multidisciplinary team initiative aims to deliver person-centred sensory modulation programs to residents with dementia.
 A new engagement tool has been developed to record and document residents'

participation in activities and roll out of the tool is near completion supported by clinical facilitator. The will ensure more detailed recording of residents participation and engagement in the activities offered and alternatives offered on an individual basis. The nutritional care plans have been reviewed and amended in line with the Speech & Language Therapists recommendations.

An audit of care plans has been completed to verify the recommendations of allied health professionals are included within the care plans following reviews. There is an ongoing schedule of care plans audits in place for 2026 in each of the Units.

Subcutaneous Fluid Protocol in place within the Center for residents at risk. The nutritional care plans have all been reviewed by the staff nurse key workers. Care plan audits continue to be completed on a regular basis and corrective action plans completed to address any issues from audits.

Fortnightly MDT meetings are conducted to ensure all allied HCP's recommendations are reviewed, followed up on and implemented and care plans accurately reflect the current assessed needs.

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

The staffing levels, skill mix and deployment of staff in the Unit has been reviewed, CNM's delegated to ensure that staff are assigned to the supervision of, and engagement with, residents in communal areas.

Each residents Pool Activity Level (PAL) has been reassessed to inform activity care plan ensuring that activities are based on will and preference of the resident in line with capability.

Weekly planner to accommodate group and 1:1 activities submitted to Nursing Admin. CNM in Nursing Admin has oversight of activity staff roster and activity planning.

Roll out of revised activity programme and engagement tool has been completed in OLU 1 and is currently being rolled out in the other units supported by clinical facilitator.

In Q3 2026 new quality initiative will be introduced to the Centre by the OT who will support staff in its implementation. This Multidisciplinary team initiative aims to deliver person-centred sensory modulation programs to residents with dementia.

There are two dining rooms available in the Lodge, one in Sunset which can accommodate all the residents and one Autumn which can accommodate the nine

residents accommodated in this area.

'Able tables' have been ordered to accommodate residents in high support chairs/wheelchairs in their choice to eat in dining rooms.

Overhead hoists are provided in each of the twin rooms to support residents with their moving and handling needs.

Each resident is risk assessed to ensure their suitability, taking account of their dependency level, within a twin bedroom.

High support equipment is no longer stored within the resident's bedroom. A separate area has been identified for storage when not in use. Privacy screens are provided at each bed area to provide privacy for residents when attending to personal care and transfers.

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Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	28/11/2025
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.	Substantially Compliant	Yellow	28/12/2025

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/11/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	25/02/2026
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 and are available for inspection by the Chief Inspector.	Not Compliant	Orange	25/02/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	30/04/2026

	details responsibilities for all areas of care provision.			
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Substantially Compliant	Yellow	01/04/2026
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	Orange	01/04/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	28/04/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/04/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	30/01/2026

	reviewing fire precautions.			
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 and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	01/01/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/12/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/01/2026
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	Substantially Compliant	Yellow	28/11/2025

	person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	26/11/2025
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	28/02/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	28/02/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake	Not Compliant	Orange	28/02/2026

	personal activities in private.			
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