



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

Issued by the Chief Inspector

Name of designated centre:	Lourdesville Nursing Home
Name of provider:	Seamus Brennan
Address of centre:	Athy Road, Kildare Road, Kildare Town, Kildare
Type of inspection:	Unannounced
Date of inspection:	03 June 2026
Centre ID:	OSV-0000060
Fieldwork ID:	MON-0049920

About the designated centre

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

Lourdesville Nursing home is located in the vicinity of Kildare town and close to many areas of interest, including the Curragh, Curragh racecourse, Japanese Gardens, the National Stud and accessible shopping. The centre was originally operated as a private maternity unit and has been developed and extended over the years. The centre now operates from the ground floor only. Bedroom accommodation consists of 26 single rooms, 5 Twin bedrooms and 2 three bedded rooms. Of these rooms listed 8 are ensuite. Communal accommodation includes a large dining, day rooms, conservatory, quiet room, small dining room, activities room and smoking cabin. There is access to a secure outdoor patio/garden area at the side and large landscaped gardens to the front, with ample parking to the front of the centre. The centre can accommodate a maximum 42 residents, male and female residents over the age of 18, of varying dependencies, for long and short-term stays. 24-hour nursing care is provided to cater for various needs, including dementia and people with chronic mental health needs, rehabilitation, palliative care, respite, convalescence and post-operative care. The registered provider is a sole trader and employs approximately 43 staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	37
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 June 2026	09:30hrs to 17:35hrs	Aislinn Kenny	Lead
Thursday 11 June 2026	10:00hrs to 15:20hrs	Aislinn Kenny	Lead
Thursday 11 June 2026	10:00hrs to 15:20hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

This inspection was conducted over two separate days. During the first, one inspector spent time in the centre to see what it was like for residents living there, on the second day, a second inspector joined and further reviewed staff and residents' files and contracts of care. Throughout the inspection, the inspectors spoke with many residents and with approximately ten residents in more detail. All residents spoken with were complimentary of the service and the staff. One resident told inspectors 'the staff are great, they look after me so well'. Another resident told the inspector 'staff are very kind, the food is tremendous.' Inspectors observed that although the residents were well cared for by staff, significant concerns were identified in respect of record-keeping and improvements were required to ensure the safety of the residents and compliance with the regulations which will be discussed further in the report.

During the first day of the inspection the inspector observed urgent risks in relation to Regulation 8: Protection and Regulation 21: Records. For example, from a review of a sample of staff records the inspector observed that four out of six staff had commenced their employment in the centre before their Garda vetting disclosure was received. An urgent action was issued to the provider to provide assurance to the Chief Inspector that all staff working in the centre had current vetting. The urgent compliance plan returned by the provider did not provide appropriate assurances which prompted the second inspection day. By the end of the second day inspectors were assured that there were no staff working in the centre without a Garda vetting disclosure. This is discussed further in the report.

The second day of inspection focused on reviewing records and contracts of care. Inspectors observed that residents were being inappropriately charged for services which they should have been provided free of charge including laundry services and general practitioner (GP) services. Inspectors spoke with six residents who reported that they were satisfied with the care and laundry arrangements but said they did not know who paid for it. One resident said that a friend was helping them by doing their laundry so they did not have to pay. Staff who spoke with the inspectors confirmed that on admission residents were being provided with the choice of taking the laundry home or paying for the service within the nursing home.

The designated centre is spread out over one floor which contains residents' bedrooms and communal areas such as conservatories, a sun-room, dining rooms and a day room. There are staff areas such as store rooms, staff changing rooms and canteen accessible via a link corridor from the main building. The front gardens were nicely landscaped with various sitting areas for residents and the provider had completed work on a new wooden seating area at the front of the centre which residents said they were looking forward to using.

On the first morning of the inspection the inspector arrived to the centre and walked around the building. The inspector observed that some areas of the designated centre were not cleaned to an appropriate standard. While residents' bedrooms were seen to be mostly clean and tidy, staff areas such as the staff canteen and some communal bathrooms were visibly unclean. The premises was laid out to meet the needs of the residents and residents were observed relaxing in their bedrooms and gathered in the communal areas throughout both days of the inspection. Some areas of the premises required maintenance and the inspector observed staff areas that were both unclean and in need of some repair.

Residents were observed spending their time watching television in the day room and conservatory at the front of the building, a small number of residents were in other communal areas of the centre. On the morning of the first day of the inspection the inspector observed that a large number residents in the front day room were unsupervised for a period of 10 minutes, an external door was open at the time due to contractors working in the centre and while staff were in close proximity there was no staff member directly supervising. Shortly after bringing this to the attention of management an activities staff member who had been doing a one-to-one activity arrived to supervise the residents. On the second morning of the inspection residents were observed watching television in these areas and were also receiving visitors in other areas of the centre. Some residents were playing cards and chatting with each other in the communal areas.

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

Capacity and capability

Overall, the inspectors found that the oversight and governance arrangements in this centre were not sufficient to proactively identify, respond to, manage and effectively protect the residents from abuse and identify issues with contracts of care.

An urgent action was issued to the registered provider following the first day of inspection in respect of significant concerns identified. The response provided did not give the required assurance and while inspectors were assured that all staff working in the centre had Garda vetting in place by the second day of the inspection, there were further findings in respect of contracts of care which are discussed further in the report. Consequently, notwithstanding the good clinical care that residents received, there were significant failures of the governance and management arrangements and ineffective and insufficient systems in place to

ensure the service provided was safe, appropriate, consistent and effectively monitored.

This was a two-day unannounced inspection carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). The provider had submitted an application to renew the registration of the centre. Overall, the centre had a good regulatory history however, this inspection found significant decline and concerning practices which did not safeguard the residents living there. Due to the significant concerns identified, a warning meeting was held with the registered provider following the inspection. Action was required by the registered provider to ensure a safe and high-quality service was consistently provided to the residents living in the designated centre.

Seamus Brennan is the registered provider of Lourdesville Nursing Home. The centre had a full-time person in charge, a registered nurse, who was supported in their role by an assistant director of nursing, a clinical nurse manager, a team of nursing staff, care staff, housekeeping, catering, administrative and maintenance staff. The person in charge reported to the registered provider. On the day of the inspection staffing resources required review to ensure that the numbers and skill-mix of staff was appropriate to ensure that centre was being cleaned to a sufficient standard at all times as discussed under Regulation 15: Staffing.

Although this inspection found that there were governance and management structures in place, the oversight of the service was inadequate to ensure the effective and safe delivery of care in accordance with the centre's statement of purpose and compliance with the regulations. Insufficient oversight of practices and lack of awareness of regulatory requirements resulted in the failure to recognise and report risks associated with safeguarding residents and contracts of care as evidenced further in this report.

Systems were in place to monitor the quality of the service, such as monitoring staff training and audits in areas such as care planning. Regular staff and management meetings were seen to take place and residents' meetings took place on a quarterly basis. However, while residents' input into the service was being sought and collected, the records did not always evidence that an action plan was put in place to address residents' feedback.

The inspectors found there were no full records available in relation to the investigation of a complaint and that some staff files did not contain all of the information as required by the regulations, for example written references.

Furthermore, on the second day of the inspection the inspectors reviewed a sample of seven contracts of care between the resident and the registered provider. Inspectors found that residents were inappropriately charged a flat fee to cover GP administration costs, which was not in line with the registered statement of purpose and had previously been not accepted by the Chief Inspector. There were also numerous errors and inconsistencies in respect of prescription levies and GP charges, including for the residents who had medical cards and who could have

accessed some of the services for free or lesser charges through the general medical services (GMS) scheme. In addition, under a 'dry cleaning' label, many residents were being charged for all laundry services that were already included in their overall weekly fee, which meant that in effect, residents were paying twice for laundry services. Inspectors found that there were many discrepancies in the records that related to costs being charged and which could not be explained by the registered provider. The Chief inspector requested that a full review and independent audit was carried out retrospectively in respect of current and previous residents to ensure that appropriate steps were taken to address these failures and submit assurances to the Chief inspector when completed, that residents were being charged appropriately for the service they received.

Regulation 15: Staffing

The registered provider had not ensured there was an appropriate skill-mix of staff related to the assessed needs of the residents and the size and layout of the designated centre. This was evidenced by:

- The day room was unsupervised for a period of time on the morning of the first day of the inspection as staff allocated to this area were attending to other residents in their bedrooms. No alternative arrangements had been made to ensure residents would be supported if need arose. In addition, an external door was open at the time due to contractors working in the centre which posed a further risk to residents.
- From a review of rosters inspectors found that a staff member's statutory leave had not been covered which meant that over a period of two weeks, at times, there was only one housekeeping staff on duty instead of three to cover all areas of the centre. This was not appropriate to maintain the cleanliness standard required and meet the needs of the residents, as evidenced by the areas in need of appropriate cleaning during the inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had not received training in the management 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). More than three quarters of residents living in the centre had dementia or a cognitive impairment.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider had not ensured that the records set out in Schedules 2, 3 and 4 were kept in the designated centre and were available for inspection by the Chief Inspector. A full review of staff files was required. A sample of six staff files reviewed found that not all information as required under Schedule 2 was available for inspection. For example:

- One staff file reviewed did not contain any information relating to their employment history and contained only a Garda vetting certificate.
- Three staff files reviewed did not contain any evidence of any relevant qualifications or accredited training of the person or evidence of the persons identity or references of employment.

Record keeping was poor and there were numerous discrepancies and inconsistencies in invoices seen by the inspectors in respect of charges levied to the residents.

There was no record available in the designated centre in respect of the charges to residents, including any extra amounts payable for additional services not covered by those charges and the amounts paid by or in respect of each resident.

Judgment: Not compliant

Regulation 23: Governance and management

Staffing resources were not aligned with the minimum staffing levels as registered in the statement of purpose and required review to ensure the effective delivery of care. For example:

- Cleaning resources were not sufficient to maintain an appropriate standard of cleanliness throughout all areas of the centre and effectively protect the residents from the risk of cross-infection.
- There was a clinical nurse manager also working as a staff nurse at times to cover maternity leave which further weakened the supervision and oversight structures.

The provider's management systems failed to ensure that the service provided was safe, appropriate and effectively monitored to ensure residents' rights were upheld at all times. For example:

- The registered provider did not ensure that all reasonable measures were in place to protect residents from abuse. Financial records reviewed by

inspectors did not provide assurance that the residents were provided with clear and transparent information regarding their monthly fees and invoices.

- Inspectors were not assured by the systems in place to appropriately charge and monitor residents' monthly fees. Systems of oversight relating to the charges were not evident on the days of the inspection. A warning meeting was held following the inspection with the registered provider to address these concerns.
- The management systems in place to provide assurance that all staff had Garda vetting in place before beginning employment at the centre were ineffective. Inspectors issued an urgent action plan, and the provider's response did not provide satisfactory assurances, which resulted in a follow up inspection day.
- There was repeated non-compliance in respect of Regulation 34: Complaints as the inspectors found that previous commitments given by the registered provider after the last inspection were not implemented and there was no clear process and procedure in respect of the management of complaints.
- Some Schedule 5 policies had not been implemented into practice. For example; Recruitment, selection and vetting of staff, prevention, detection and response to abuse and management of complaints.
- There was no action plan in place following residents' meetings to ensure that residents' feedback was implemented.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

From a sample of contracts reviewed the inspectors found that the details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, and the relevant fees to be charged to the resident were not clearly outlined or followed by the provider, thus creating a risk of financial abuse.

The contracts of care also did not include other services which the residents may choose to avail of but which were not included in the Nursing Home Support Scheme, or to which the resident is not entitled under any health entitlement. For example, hairdressing charges were not listed, and inspectors saw evidence of residents being invoiced for such service, when provided.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider's statement of purpose submitted with their application to renew the registration of the centre required review to ensure the number of staff

nurses working in the centre was accurate and the complaints procedure was in line with the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in Schedule 4 of the regulations, were notified to the office of the Chief Inspector within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

- The registered providers policy for dealing with complaints was not in line with the regulations.
- The complaints procedure on display did not set out details of advocacy services or a time frame of which the complaint would be responded to. It also named the person in charge after the contact details for the complaints officer which may cause confusion as to who to report complaints to.
- While the number of complaints received in the centre was low, from a review of a complaint received since the last inspection the complaints procedure was not followed. For example: The complaint was not responded to appropriately within the time frame set out by the regulations and was responded to by the person in charge and provider, as well as the named complaints officer.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that the provider was, in general, delivering a good standard of care and support to residents. Residents were provided with some opportunities for social activities and were encouraged to spend their days in the manner that they chose. Some areas of the premises and infection prevention control did not fully comply with the regulations, and as such could present a risk to the care and welfare of residents. Residents' rights were primarily upheld however, improved communication was required between the provider and residents in

relation to their choice of services and additional fees charged. The inspectors observed that the privacy and dignity of residents was respected by staff. Staff interacted with residents in a caring, patient and respectful manner.

Inspectors observed that staff were very familiar with residents' medical history, individual needs and preferences. Residents were assessed for a variety of clinical risks. Care plans reviewed by the inspector were generally personalised, and sufficiently detailed to direct care.

A transfer document was used when residents were transferred to the hospital. This document contained details of health-care associated infections and colonisation to support the sharing of and access to information within and between services. Discharge summaries were obtained on residents' readmission to the centre.

The premises was largely well-maintained and there was evidence of ongoing maintenance on the day of the inspection with an upgrade to heating systems taking place. However, some staff areas were unclean and required maintenance as discussed under Regulation 17: Premises.

The inspector identified some examples of good practice in the prevention and control of infection. For example, staff were observed to apply basic infection prevention and control measures known as standard precautions such as hand hygiene, to minimise risk to residents, visitors and their co-workers. However, a number of practices were identified which had the potential to impact the effectiveness of infection prevention and control within the centre. For example, some bathrooms and items of equipment were also observed to be visibly unclean. Findings in this regard are presented under Regulation 27: Infection prevention and control.

Staff spoken with demonstrated good understanding of what to do if they witnessed an incident of abuse or if a resident raised a concern with them. The registered provider was not a pension-agent for any resident however; the provider did not demonstrate adequate insight into the risk of financial abuse. This is discussed further under Regulation 8: Protection.

Regulation 17: Premises

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

- Floor covering in some areas required review such as lino bubbling at the staff changing areas and there was staining on the floor covering in the dining room.
- There was maintenance required in some internal areas, such as damp was observed on the wall in the area where hoists were being charged;
- There was inappropriate storage observed as hairdressing supplies were also stored in the area where hoists were being charged.

- Rust was observed on some commodes, which meant that equipment to be used by residents could not be effectively cleaned.
- Not all bedrooms contained a lockable storage space and secure facility for the safe-keeping of residents' personal money and valuables.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Where the resident was temporarily absent from the designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 27: Infection control

The provider did not meet all the regulatory requirements and the *National Standards for infection prevention and control in community services (2018)*. For example:

Areas within the centre did not support effective infection prevention and control. For example, there was chipped paintwork and breaches of integrity in tray tables and the residents' beds, which could not ensure effective cleaning.

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

- The staff changing room was visibly unclean with dirt on the floor, cabinets and walls. The staff canteen area also required a deep-clean to ensure equipment such as the sink, fan and bin were cleaned to an appropriate standard.
- Tiles in communal bathrooms were visibly dirty and also required a deep clean. Cobwebs were observed in one bathroom and it had not been cleaned to an appropriate standard.
- Dust and cobwebs were observed in the visitors lounge and chairs were visibly stained with paint.
- Commodes were being used as shower chairs; while some shower chairs had been purchased this was a repeat finding from the last inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Based on a sample of care plans viewed appropriate interventions were in place for residents' assessed needs. Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs.

Judgment: Compliant

Regulation 8: Protection

While there were some arrangements in place, The registered provider did not ensure that all reasonable measures had been taken to protect residents from the risk of abuse. Urgent action was required in this area to ensure the sufficient protection of residents. This is evidenced by:

- From a review of staff files and rosters it was evident that four staff working in the centre had commenced employment before their Garda vetting disclosure had been received by the provider. This created a risk to residents' safety and was in breach of the registered provider's own policies and procedures and the regulations. On the first day of inspection and in the response to the urgent compliance plan request, the provider could not provide assurance that all staff working in the centre had a current garda vetting in place.
- Inspectors reviewed a sample of residents' monthly invoices. This review along with supporting documentation and correspondence, contained numerous inconsistencies for which the provider could not provide a clear rationale. Residents were incorrectly charged twice for laundry services they were already paying for or were being charged in a manner that was not appropriate such as for monthly routine reviews by GP in the absence of a clinical need. In addition, residents with medical cards were being incorrectly charged for prescription levy well in excess of what they should have been paying, as per nationally agreed charges.
- On the first day of the inspection, inspectors found that three staff had not completed the mandatory training in safeguarding adults and recognising abuse. This gap had not been identified by the provider as a safeguarding risk.
- The contact details for one advocacy service displayed in the centre contained historical information and a contact number that was no longer in use. This continued to be on display despite assurances that it would be removed following the last inspection, in June 2025.

Judgment: Not compliant

Regulation 9: Residents' rights

- An area was identified where residents were not provided with appropriate information to make informed choices. While residents confirmed to inspectors that they were asked if they would like to avail of the outsourced laundry service that the provider utilised in the centre, they were not provided with the appropriate details to inform this choice, for example that laundry services were already included in their weekly fee under the Fair Deal Scheme.
- It was also not made clear to residents that laundry service that was provided was not 'dry cleaning' as set out in the contract of care.

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	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lourdesville Nursing Home OSV-0000060

Inspection ID: MON-0049920

Date of inspection: 03/06/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider acknowledges that at times there was inappropriate skill mix of staff related to the assessed needs of the residents. It has become evident the main time for lack of supervision in the day room is early morning when residents are assisted with ADL's therefore we have allocated the Activities Co-Ordinator to engage with the residents regarding the morning affairs, news, newspapers etc. while having their breakfast. The allocation roster has been revised to ensure a staff member is on duty within the vicinity at all times to provide supervision and assistance as required. Staff have been informed via staff meeting of the importance of remaining vigilant and maintaining appropriate supervision of residents in line with their assessed needs. A staff member will be allocated to each section of the house to ensure the safety and quality of care of residents being delivered is of a high standard. It was identified that there was shortage of staff to cover statutory leave. The inspection took place during a time of reduced housekeeping staff due to sick leave and annual leave this impacted the standard of cleanliness required to meet the needs of the residents. Arrangements have been reviewed to ensure essential duties are maintained during episodes of reduced staffing with improved contingency measures re deployment of staff, and PIC reviewing staffing levels daily. A new housekeeping staff member has been assigned on 06.07.2026 on receipt of Approved Garda Vetting. Due to her work ethic and commitment within the centre she has proved a notable difference in the appearance, cleanliness and overall housekeeping standards and therefore has been appointed head of housekeeping. The ADON/CNM2 will oversee to ensure each area has a staff member present at all times to meet the needs of residents.	

The PIC will monitor staffing levels daily and complete monthly roster audits to ensure adequate staffing and skill mix are maintained in line with residents assessed needs. The provider gives assurance that staffing levels and skill mix of staff will be maintained to meet the assessed needs of the residents and support the safe delivery of care.

Regulation 16: Training and staff development

Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

The Register provider acknowledges and identifies there was a gap in our Mandatory Training where staff had not received Training in the Management of Responsive Behavior and also three staff did not have Safeguarding.

As per Regulation 16 1(a) the PIC has ensured that all staff have undertaken mandatory training in Management of Responsive Behavior and Safeguarding and received their certification in same, which is reflected in the Training Matrix.

Management will ensure all new staff will receive immediate training on taking up employment within the Centre. The CNM 2 will conduct six monthly audits of the Training Matrix to identify those who require re-certification. Audit findings will be discussed at management meetings and training will be arranged as required to maintain compliance. The provider gives assurance that Staff Training will be monitored to ensure ongoing compliance.

Regulation 21: Records

Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

The register provider acknowledges that some records set out in schedule 2,3,4 were not kept in the designated Centre and were not available for inspection. On review of all staff files it was discovered some documentation as per schedule 2 was absent. A template was created outlining all requirements as per schedule 2 and attached to each file with a tick box identifying all the required documents were in place. Relevant staff were contacted to provide the necessary documents. As this is the holiday period six

weeks is allowed for these documents to be provided. The ADON will be responsible for ensuring all documentation is provided, six monthly audits of staff files will be conducted by the ADON and any gaps identified will be addressed.

It has been observed and accepted that there were errors in some Invoices. A review of all files has been carried out and reimbursement by cheque or credit note in collaboration with resident or relevant person has taken place.

In order to prevent the recurrence again a template has been generated by the Provider, detailing the breakdown of charges which will be cross checked with the monthly invoices, by the PIC and counter checked by the ADON. Due to technical difficulties records of charges to residents were unintentionally not downloaded. This was a significant oversight and did not meet the requirements of best practice or regulation 21.

. A monthly review of Invoice records has been introduced to ensure all required documentation is available and discrepancies identified and addressed immediately. All records specified in Schedule 2,3,4 will be accurately maintained and reviewed monthly by PIC, ADON, and available for inspection as required.

The provider gives assurance that records will be accurate, complete and regularly reviewed,

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Registered Provider acknowledges staffing levels were not aligned with the minimum staffing levels as registered in the SOP. Staffing arrangements have been reviewed. The PIC will monitor staffing levels and rosters to ensure they reflect the numbers on the SOP. Staffing will be discussed at regular governance meetings with any issues identified brought to the attention of the provider for prompt action.

Another housekeeping staff member has been recruited and commenced employment on 06.07.2026.

The CNM2 may occasionally provide clinical cover to support safe staffing if required.

This will be in exceptional circumstances and the ADON will work in the CNM role to ensure continuity of leadership and supervision, management oversight and monitor the effectiveness of clinical governance processes.

We are in the process of recruiting two Staff Nurses and are awaiting their documentation and start date.

A review of financial records identified issues relating to the transparency of monthly fees. The contract of care referred to dry cleaning rather than laundry, resulting in the

arrangements not being clearly outlined while the provider acknowledges that the invoicing process was not sufficiently transparent it was an inadvertent error whereby a laundry charge had been applied for approximately six years. While residents and their representatives were aware that laundry charges were being applied, the provider now recognizes that this practice does not align with contractual arrangements of the nursing home support scheme and has therefore been discontinued with immediate effect. A comprehensive review of residents invoices identified a number of residents who had been incorrectly charged. All current residents have been reimbursed by cheque or credit note. Where residents have since passed away reimbursement of relevant fees will be made to their estates by November 1st.2026.

On completion of reimbursement of laundry fees a review and investigation will commence on GP fees.

Contracts for new residents have been updated and contracts for existing residents have been amended.

The registered provider has undertaken a full review of governance and oversight systems in relation to financial records. Additional validation measures have been implemented when generating an invoice to ensure the correct amounts are charged, six monthly audits, monitoring a clear schedule of charges which matches each residents contract, PIC and ADON checking and signing off invoices before they are issued, regular management review of billing records to identify discrepancies with prompt correction if errors occur.

Audit findings will be reviewed through the centers' clinical governance and management processes to ensure ongoing compliance and continuous quality improvement and ensure charges are in accordance with regulatory requirements.

The registered provider acknowledges that the systems of oversight were not sufficient to ensure Garda Vetting was completed prior to a small number of staff commencing employment. In addition the provider acknowledges that the urgent action plan submitted did not provide sufficient assurance that effective management systems were in place to prevent recurrence.

Governance arrangements have since been strengthened. A pre-employment checklist has been introduced to ensure all schedule 2 documentation including Garda vetting are in place and must be completed and signed off by the Person in Charge prior to confirming a start date. Annual audits of staff files will be completed by the ADON. Audit findings will be reviewed through governance meetings and any identified deficits addressed promptly through a documented action plan, with progress monitored to completion.

The provider gives assurance that no staff member will commence employment in the LNH until a satisfactory Garda vetting disclosure has been received and verified in accordance with regulatory requirements.

The Provider confirms that all staff currently employed in Lourdesville Nursing home have current Garda Vetting in place.

The registered provider acknowledges that governance arrangements relating to the management of complaints were insufficient to ensure a clear and consistent process and procedure was in place. The complaints policy and procedure have been reviewed and revised to ensure compliance with Regulation 34. A standardized complaints management process has been implemented to ensure all complaints are acknowledged, recorded, investigated, responded to and closed within the required timeframes.

Monthly audits of complaints log will be completed by the ADON and findings reviewed at governance meetings. The Person in Charge will oversee the effectiveness of the complaints process and will ensure that learning arising from complaints are identified, shared with staff where appropriate and used to inform continuous quality improvements.

The registered provider acknowledges that systems of oversight were not sufficiently effective to ensure the consistent implementation of Schedule 5 policies in practice. The governance arrangements detailed within this compliance plan have strengthened policy implementation with ongoing monitoring through audits, governance meetings, and management oversight to ensure sustained compliance.

The registered provider acknowledges that, while feedback from residents was acted upon, there was no formal action plan in place to document actions arising, allocating responsibility, or monitor progress to completion. A standardized residents meeting action plan has now been implemented to record all actions arising from resident feedback, identify the person responsible for each action, and specify target completion dates. Progress will be reviewed at our residents meetings and governance meetings to ensure feedback is acted upon and used to improve the quality of care and services. The provider gives assurance that Governance and Management systems have been strengthened to ensure effective oversight monitoring and continuous improvement within L.N.H.

Regulation 24: Contract for the provision of services

Not Compliant

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

The registered provider acknowledges that governance arrangements relating to contracts of care and charging practices were not sufficiently effective to ensure that all services provided and associated fees were clearly outlined and accurately reflected within residents' contracts of care. A comprehensive review of contracts of care and charging arrangements have been completed, with contracts updated to ensure all charges are transparent and in accordance with regulatory requirements. Enhanced oversight and review processes have been implemented to ensure ongoing compliance, transparency and protection of residents from the risk of inappropriate charging. The registered provider gives assurance that these strengthened governance arrangements will prevent a recurrence of the issues identified. All current residents laundry fees have been reimbursed. Outstanding fees due to residents no longer within LNH will be reimbursed by November 1st.2026 The Report states residents were Invoiced for

Hairdressing, a comprehensive review of all residents Invoices for 2025 & 2026 identified one Invoice which included a hairdressing charge. This charge was in line with the residents Contract of Care which states residents are responsible for the cost of personal services such as hairdressing. The relevant person had requested the provider to pay the Hairdresser and include the hairdressing on the next Invoice. A detailed charging template has been implemented with all invoices subject to cross checking by PIC and ADON before being issued.

Regulation 3: Statement of purpose

Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The Statement of Purpose did not accurately reflect the current nursing compliment. At present Lourdesville Nursing Home has seven staff nurses while the SOP states eight staff nurses.

The Register Provider is actively engaged with a recruitment agency and provides assurance that two additional staff nurses are scheduled to commence employment 9th. November 2026 approximately.

The SOP will be reviewed regularly to ensure it accurately reflects the nursing compliment of Lourdesville Nursing Home

Regulation 34: Complaints procedure

Not Compliant

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

The Registered Provider acknowledges that the complaints procedure was not fully compliant with Regulation 34. The complaints policy and procedure has been reviewed and updated to ensure full compliance with the regulatory requirements. Details of the independent Advocacy services are now clearly displayed within LNH and included in the Complaints information available to residents and their representatives. A standardized template has been implemented to ensure all complaints are acknowledged, recorded, investigated, responded to and closed in accordance with Regulation 34. The Register Provider gives assurance that all complaints will be managed in line with the revised complaints procedure and regulatory requirements.

Monthly audits of the complaint log will be completed by the ADON and findings

reviewed at governance meetings. PIC will oversee effectiveness of the complaints process through audit reports and governance meetings to assure any issues identified are addressed promptly.

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Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider acknowledges that aspects of the premises required improvement to assure full compliance with Regulation 17. All finding in the report have been addressed. Floor covering in the Dining room has been replaced. The Staff room flooring is scheduled to be replaced within the next three weeks. All damaged equipment has been disposed of and replaced. The hairdressing supplies which were identified as being stored inappropriately were no longer in use.

Following the inspection these items were removed from the premises. A review of residents storage arrangements have been completed and residents requiring additional secure storage facilities have been identified. Appropriate lockable storage will be provided by 31.08.2026 to ensure safe storage of personal belongings.

. A structured programmed of planned maintenance and environmental audit has been established to ensure that premises are maintained to the required standard.

The PIC will oversee the environmental audits and findings reviewed through Governance meetings, and required improvements reviewed until completion.

The Register provider gives assurance that the premises will be maintained in accordance with Schedule 6 of the regulations and will meet the needs, safety and welfare of residents.

Regulation 27: Infection control

Substantially Compliant

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

The Registered Provider acknowledges that cleaning standards of some areas within LNH did not consistently meet the required standards. All areas identified were deep cleaned immediately following the inspection. Cleaning schedules have been reviewed and strengthened.

A fourth experienced member has joined our housekeeping team on 06.07.2026. An improved audit system has been implemented to identify any deficiencies in cleaning standards.

Audit findings will be reviewed by the PIC through Governance Meetings, issues identified will be highlighted and addressed promptly. The report found commodes were being used as shower chairs, the equipment referred to in the inspection are Bariatric Attendant Shower & Toileting chair which are designed for both showering and toileting. The Registered Provider gives assurance that effective oversight arrangements are in place to ensure LNH is maintained to a high standard in accordance with Regulation 27 and Infection Prevention Control guidelines.

Regulation 8: Protection	Not Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection:
The Registered provider acknowledges that four staff members commenced employment before Garda vetting had been received. Although satisfactory Garda Vetting disclosures had been obtained for all four staff members by the date of inspection, this practice did not comply with Lourdesville Nursing Home's recruitment policy or the requirements of the regulations. The provider also acknowledges that the systems in place at the time did not provide inspectors with immediate assurance that Garda vetting had been completed for all staff.

A Comprehensive review of all staff files was completed, confirming that all staff employed in LNH now have up to date Garda vetting in place. Recruitment procedures have since been strengthened, with a pre- employment check list to ensure Garda vetting is obtained before a start date is confirmed. A Garda vetting register has been introduced and reviewed annually by ADON to provide ongoing assurance of compliance.

The Registered provider acknowledges that inconsistencies were identified in some residents' invoices where no clear explanation could be provided this was a significant oversight and an inadvertent error on behalf of management. A full review of resident's invoices was conducted and all fees incorrectly charged have been reimbursed. During the review two residents were identified as being charged incorrectly for the prescription levy, a clear justification was unable to be provided for this error. This fee has been fully reimbursed. The invoicing process has been reviewed and strengthened to ensure charges are applied strictly in accordance with the residents' contract of care. A clear schedule of chargeable services has been implemented, and invoices will be cross checked and verified by the PIC and ADON before being issued.

Monthly audits will be undertaken by the PIC to ensure accuracy and compliance with contracts of care. Audit findings will be reviewed through governance meetings and any discrepancies will be addressed immediately.

The Registered provider acknowledges that three staff members had not completed the required safeguarding adult training at the time of inspection. While the provider was

aware that these staff members had not yet completed the training, this gap was not formally identified, recorded or managed as a safeguarding risk through the LNH risk management process. A review of the mandatory training matrix has been completed. All staff are now compliant with safeguarding training. The CNM2 will conduct six monthly audits of the mandatory training matrix, and any outstanding mandatory training will be recorded on the risk register and discussed at governance meetings. The PIC/ADON will review mandatory training compliance routinely. The provider is determined to ensure residents are safeguarded from abuse through effective governance, staff training and ongoing oversight.

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Registered provider acknowledges residents were not provided with clear and accurate information regarding laundry services which impacted the residents informed choice. All residents contracts of care were reviewed and seventeen of the current residents were identified as being charged incorrectly. Each resident or relevant person was issued with a letter and verbally informed of the error. Clarification was given on the difference between Laundry and Dry Cleaning. All fees have been reimbursed to current residents. A review of previous residents are presently being conducted and completion and reimbursement will be by 1st.November 2026. The person in charge will complete monthly Audits of Contracts of Care, and Invoices to ensure information remains accurate, consistent and supportive of residents to make informed choices. Any discrepancies identified will be addressed immediately. The provider gives assurance that systems are in place to ensure residents receive the information and support they need to make informed choices	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	06/07/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	10/07/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/08/2026

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	11/09/2026
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	06/07/2026
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	04/06/2026
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	Not Compliant	Orange	20/07/2026

	number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 24(2)(a)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.	Not Compliant	Orange	20/07/2026
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Not Compliant	Orange	20/07/2026
Regulation 24(2)(c)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of where appropriate, the arrangements for the application for or receipt of	Not Compliant	Orange	01/11/2026

	financial support under the Nursing Homes Support Scheme, including the arrangements for the payment or refund of monies.			
Regulation 24(2)(d)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the resident is not entitled under any other health entitlement.	Not Compliant	Orange	20/07/2026
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.	Substantially Compliant	Yellow	06/07/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned	Substantially Compliant	Yellow	28/07/2026

	and containing the information set out in Schedule 1.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Not Compliant	Orange	28/07/2026
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	20/07/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any	Not Compliant	Orange	20/07/2026

	improvements recommended and details of the review process.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	15/06/2026
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	10/07/2026
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	01/11/2026