Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Lemongrove House
Name of provider:	Resilience Healthcare Limited
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	15 January 2026
Centre ID:	OSV-0007634
Fieldwork ID:	MON-0049114

About the designated centre

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

Lemongrove House is a residential home for adults, located in a town, in Co. Wexford. Residential services are provided to adults, both male and female. Up to six residents can be accommodated at any one time. Communal areas include a dining room, living room and kitchen with a separate larder room for food storage. Recreation and leisure space is provided in the garden area. The statement of purpose describes the environment as aimed at the needs of people with a particular, identified, genetic condition. Services are provided in Lemongrove House for persons with a particular genetic condition who present with complex medial and behavioural support needs. The statement of purpose outlines the ethos as providing support in a manner promoting independence, based on individual needs. The service is described as a community based service where staff encourage residents to enjoy the benefits of the local community and social facilities. Vehicles are allocated to the house to support community access. Staff support is by way of a team of support workers supported by a multidisciplinary team. The numbers, qualifications and skills-mix of staff is described in the statement of purpose as 'appropriate to the number and assessed needs of the actual residents taking into account the size and layout of Lemongrove House'.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 15 January 2026	09:30hrs to 18:00hrs	Linda Dowling	Lead
Thursday 15 January 2026	09:30hrs to 18:00hrs	Sinead Whitely	Support

What residents told us and what inspectors observed

This was a risk based inspection following receipt of information by the Chief Inspector of Social Services through the concerns team. The inspection was unannounced, completed over one day by two inspectors.

Overall, the findings indicated that while the provider was striving to deliver care in a person centred manner and the residents in the centre were engaging well in their community, there were a number of areas that required improvement. These finding included the staff rota, service auditing systems, notifications of incidents, risk management, safeguarding procedures, medication management and resident rights.

Lemongrove house is registered to provider residential services for up to six adults, at the time of inspection there was one vacancy in the centre. The premises is a large detached two-storey house and comprises six self-contained apartments and a number of communal areas include a gym, dining room, living room and kitchen with a separate larder room for food storage.

When the inspectors arrived, one resident greeted them at the door with their support staff, they welcomed the inspectors into their home. The staff requested the inspectors sign in while they made contact with the person in charge. Residents were observed to be moving around the centre with ease and with their support of staff, some were having breakfast and others were finished and getting ready for their planned activities.

A full walk around the premises was completed and this was facilitated by the centres team leader. Overall, the premises was found to be suitable to the needs of the residents although, as identified in the last inspection, there was significant wear and tear damage throughout the property. A number of areas were noted as requiring paintwork. Scratches and chips to paintwork were observed on walls, doors, window sill, stairs and skirting boards. Some painting works had commenced on the day of inspection. Apartments had all been personalised in line with the residents needs and preferences. Pictures, photo's, artwork and personal belongings were observed in all apartments.

Inspectors had the opportunity to meet with the five residents living in the centre throughout the inspection day. On the morning of the inspection, residents were getting ready for the day ahead and going about their normal daily routine. One resident was in the centres living room and told inspectors that they were heading out for a coffee with staff. Another resident was present and watching cartoons. Another resident met with an inspector in their apartment. The resident told the inspector that they were going to a local dance class. When asked, the resident told the inspector that they loved living in Lemongrove and really like the staff

supporting. Happy, familiar and positive interactions were observed between staff and residents throughout the day.

Later in the morning, an inspector met with another resident in their apartment. The resident was listening to music and preparing a chart for the upcoming World Cup and they appeared very happy doing this. The resident told the inspector that they were heading out to the local pub later for a drink with a staff member and they were looking forward to this.

During the inspection, the inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included conversations with each resident living in the centre, the person in charge and team leader, three staff members and family members. Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and how the providers ensures appropriate oversight and monitoring of the quality of care and support in the centre.

There was high staffing levels in place in the centre with all residents supported at a minimum of one to one. The inspectors spoke with staff who reported that they enjoyed working in the centre and found that management were supporting them in their role.

A number of restrictive practices were observed in use around the centre and inspectors found that these were in place due to identified risks. Rationale for these were clear had corresponding risk management documentation.

All families were made aware of the inspection and two made contact with the inspectors. One family member identified a number of concerns they have in relation to their adult child's care the other family member highly commended the supported given to their sibling and how all staff and management are a pleasure to deal with.

The provider had identified a significant increase in complaints and were taking responsive actions in relation to these. The centre had sought support from the head of health and safety in formally responding to these complaints.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

Overall, the inspectors found that there was a clearly defined management structures in the centre which was led by a person in charge who was supported in their role by a team leader. While some actions had been appropriately addressed since the centres most previous inspection in May 2025, the inspectors identified a

number of areas that continued to require improvements. This included findings in relation to the staff rota, service auditing systems, notifications of incidents, risk management, safeguarding procedures, medication management and resident rights.

Regulation 15: Staffing

There was a large staff team employed in the centre and high staffing levels in place at all times, in line with the residents assessed needs. There was an appropriate skill mix to meet the needs of the residents. Residents were observed to approach and speak to staff with ease.

Residents were all supported at minimum one to one during the day. The inspectors reviewed a sample of three months of the staff rota and found that this was not in line with the centres whole time equivalent (WTE), as identified on the centres Statement of Purpose. Staff allocations and roles were also unclear at times. For example differences between nursing staff, members of management and care workers were unclear on the rosters.

Staff personal files were not reviewed as part of this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that the provider had good governance and management arrangements in place to monitor and oversee residents' care and support. There was a clearly defined management structure in place which was led by the person in charge who also had responsibility for one other designated centre operated by the same provider. The person in charge reported to the regional manager and was supported in their role by a full time team leader and two assistant team leaders who worked across day and night shifts in the centre. There was an on-call roster in place to ensure that support was available for residents and staff out-of-hours.

The provider's systems to monitor the quality and safety of service provided for residents included; unannounced provider visits every six months, area specific audits, and an annual review.

Inspectors reviewed the report following the last six-monthly unannounced visit to the centre which had occurred in July 2025. This had been completed by the service quality team and in general it was found that this had appropriately self-identified areas in the centre in the need of improvements. A clear action plan had been

developed following this audit along with timelines for completion of outstanding actions.

The annual review for 2025 had not yet been completed at the time of inspection. A number of regular internal checks and audits were being completed by staff and management. Inspectors found that these were not always self-identifying areas in need of improvements and overall findings from the inspection indicated that further improvements were needed to ensure higher levels of compliance with the regulations reviewed. For example a number of concerns were noted in the area of medication management on the day of inspection and these had not been previously noted during internal checks. Furthermore, findings in relation to safeguarding and risk management were not being appropriately recognised during checks and audits.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

On review of the notification that had been submitted to the Chief Inspector of Social Services since the last inspection against the providers own incident and accident records. Information had not been submitted accurately and in line with the centres own records. A number of notifications required follow up to clarify information in relation to the residents effected, the impact on residents and the actions taken to prevent such incidents reoccurring.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a policy and procedure in place for the management of complaints, this policy was available in the centre on the day of the inspection. Residents were made aware they could make a complaint they were informed about the providers policy through an easy to read document at their residents meetings.

The centre had received a large number of complaints in relation to a variety of concerns, these complaints were in the process of being managed as per the providers policy. The providers head of health and safety with responsibility for risk and complaints was working with the person in charge to identify the concerns and respond to the concerned person.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that some improvements were required in relation to the premises, risk and medication management, safeguarding of residents and residents' rights.

Although, good practices were observed on the day of inspection in relation to interacting and supporting residents and staff training records evidenced all staff had received safeguarding training their had been a delay in the reporting of a recent safeguarding concern and their were poor practices implemented when residents engaged in setting off the fire alarm.

Inspectors identified that compatibility issues identified in previous inspections had been resolved and the local management had ensured that clear care plans were in place that guided staff to provider care in line with residents' assessed needs.

Regulation 17: Premises

Overall the premises was maintained in a reasonable state of repair and was designed and laid out to meet the assessed needs of the residents. The premises is a large detached two-storey house and comprises six self-contained apartments and a number of communal areas include a gym, dining room, living room and kitchen with a separate larder room for food storage.

Overall, the premises was found to be suitable to the needs of the residents although, as identified in the last inspection, there was significant wear and tear damage throughout the property. A number of areas were noted as requiring paintwork. Scratches and chips to paintwork were observed on walls, doors, window sill, stairs and skirting boards. Some painting works had commenced on the day of inspection. The inspectors also noted one broken chest of drawers in a residents bedroom and some areas where residents stored their belongings required deep cleaning. There was staining noted on the floor of one residents en-suite bathroom. A rusting radiator was also observed in the centres dining room.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The centre had an up-to-date risk management policy in place. Residents all had individualised risk assessments in place and these included clear rationale for the

use of restrictive practices in the centre. Risks associated with residents particular genetic condition and their complex needs had been carefully considered. The service health and safety officer completed an audit on the health and safety measures in the centre every six months.

There was an incident reporting systems in place and the inspectors reviewed records of any adverse incidents which had occurred in the designated centre in recent months. This was an online recording system. The person in charge was the only person who could access all this information to show the inspectors records of adverse incidents in the centre. This meant that in general, information on previous adverse incidents which had occurred in the centre could not be accessed by all staff. This posed a risk of staff being unaware of potential hazards following any adverse incidents in the centre.

The centres designated smoking area and bin for cigarettes was located in an area outdoors in close proximity to the centres oil tank. Risks secondary to this proximity had not been considered by the centres staff or management. There was no designated smoking area provided for residents that met with the requirements of up-to-date fire safety guidance for smoking areas in designated centres.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors reviewed medication management systems in the centre. Overall it was found that a number of improvements were required to ensure safe practice at all times. This was seen in the following areas:

- Medication administration records were not always accurately reflective of medication administered. One resident was prescribed an antibiotic and prescription records noted that this was prescribed three times per day. However, administration records did not reflect that this had been administered three times per day since commencements. Inspectors noted too many tablets left in the box for the amount of doses that the resident should have received.
- Topical gels with contraindications were prescribed on one residents PRN (as required) kardex with no instructions for staff on the risk of contraindications.
- Antibiotics were noted on some residents PRN prescription kardex's rather than short term medication kardex's. This posed a risk of antibiotics being administered PRN rather than the short term course they were prescribed for.
- One resident had medication in their storage press that was not prescribed to them.
- One PRN protocol noted an oral medication as "topical". Another PRN protocol did not include details of the medications maximum dose in 24 hours and time intervals between doses.

- Some residents prescribed topical creams were observed to have no 'date opened' recorded in the storage facilities.
- Some residents prescribed PRN medications were not in stock in the centre.
- Management audits were being completed monthly, however these were not self-identifying these areas in need of improvements.

Judgment: Not compliant

Regulation 8: Protection

While improvements were required in relation to safeguarding and protecting residents. Residents met with on the day of inspection reported to be happy and supported. Residents were seen to be comfortable moving around the centre and seeking support from staff and management.

Residents all had intimate care plans in place which identified area's they required support and their preferences around these supports. All staff had received training in safeguarding and protection of vulnerable adults and the service trust in care process. Although from the inspectors review of a recent alleged safeguarding incident, it was found that staff had not always followed appropriate safeguarding reporting pathways. An incident which had allegedly occurred in December, had not been reported or identified as a safeguarding concern by staff until it was reported by a relative to management. A thorough investigation did however take place and appropriate actions implemented by the provider.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors had some concerns around centre practices that impacted residents rights. These required review.

Inspectors noted a practice in the centre which involved fining residents €1 when the centres fire alarm was activated unnecessarily, due to incidents of residents setting off the alarm. This had been an ongoing issue in the designated centre. Inspectors observed a sign in the designated centre which notified residents that they would be fined if the alarm was activated. Staff and management spoken with told inspectors that residents money was never actually taken from them. However, inspectors questioned the ethics and the safety of this practice considering the need to activate the alarm in the event of a real fire. The providers own six monthly unannounced audit had also questioned this practice.

Residents' meetings were being completed weekly. Inspectors reviewed minutes from these and noted that meetings were brief, repetitive and did not appear to follow the service template for residents meetings. In recent months, discussions did not include evidence of consultation with residents regarding their views on the service, complaints or plans for their week. There were no records of discussion on residents' rights, safeguarding, current affairs, or service policies. Furthermore restrictive diets were not being recorded as restrictive practice in the centre and therefore were not subject to regular review considering the impact on residents rights.
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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lemongrove House OSV-0007634

Inspection ID: MON-0049114

Date of inspection: 15/01/2026

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of the rosters has been completed, and is currently in line with the WTE outlined in updated SOP. The Staff rosters have been reviewed and are clearly defined to ensure clarity of roles and allocations of staff.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Annual Review is completed and was forwarded to the inspector on the 16th of Feb 2026. The Manager will oversee the implementation of the following documents Audit policy, Audit tools in line with Audit schedule. Service Manager will meet with team Leaders to ensure understanding and implementation of auditing tools. Team members will receive further training in the daily auditing process from the Manager and Team leaders. The service will use peer auditing from another center to cross check and ensure Audits are completed in line with policy documents and to ensure that they are completed effectively Any remedial actions identified in the audit will be closed off using the audit tool	

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All notifications will be reported in line with the regulations. The information provided at the time of reporting will be accurate, concise and up to date. Should further information be required or come to light the inspector will be updated immediately. All members of the staff team will undertake the safeguarding training again to ensure that staff have full understanding of their role in reporting

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Full review of the premises will be completed to address all maintenance works and bring the premises into full state of repair. Deep clean of the premises by an outside contractor has been completed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The providers CQI group meet monthly, all feedback from the Manager in the centre will be reviewed to include online recording system to improve access for staff. However, in the interim a desktop is now available and in place for staff to ensure awareness of potential hazards post incidents. The Providers H&S officer will work with the PIC and complete a full review of the centre to identify relocation of the Bin for Cigarettes and designated smoking area, to come into line with up to date fire safety guidance for designated Centres.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The Manager of the Centre will complete a full review of medications and management system in the centre. All medications currently present in the centre are prescribed. Full review of all PRN protocols will be completed. Medications audits will be completed only by Team Leaders or Managers. Audit frequency will be increased with the use of peer auditing from another center to cross check and ensure Audits are completed effectively to self identify areas for improvement.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: All members of the staff team will undertake the safeguarding training again to ensure that all staff are fully aware of their role in reporting. Use of Staff Knowledge tool will be completed by Team Leaders and Manager to ensure Staff understanding.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Manager will complete a full review with the RM and BSS on all RP in the centre. Restrictive Diets will be logged on the register. Residents meetings will be implemented in line with service template with evidence of discussions on residents' rights, safeguarding, currently affairs and service policies.	

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, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	18/03/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	20/04/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	20/04/2026

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	20/04/2026
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Yellow	20/04/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated	Not Compliant	Orange	18/03/2026

	centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	20/04/2026
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	20/04/2026