Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100361	A. BUILDING _____ B. WING _____	R-C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALMOUTH PERSONAL CARE HOME, LLC	406 BARKLEY STREET FALMOUTH, KY 41040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{P 000}	Initial Comments Based on the off-site survey and implementation of the acceptable Plan of Correction (PoC), received by email on 12/12/2025, substantial compliance will be achieved on 02/16/2026.	{P 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	100381	A. BUILDING _____ B. WING _____	C 10/16/2025

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P 000	Initial Comments A Relicensure and Complaint Survey was initiated on 10/14/2025 and concluded on 10/16/2025 with regulatory violations identified. No deficiencies were issued related to KY00037387, KY00037933, KY00038110, KY00039116, KY00045208, KY00045577, KY00046457, KY00046777, and KY00047304.	P 000		
P 120	902 KAR 20:036 4(10)(h) Section 4. Administration and Operation (h) In-service training. 1. Each PCH or SPCH employee shall receive orientation and annual in-service training that corresponds with the staff member's job duties. 2. Documentation of orientation and in-service training shall be maintained in the employee's record and shall include: a. Name of the individual or individuals who provided the training; b. Date and number of hours the training was given; and c. A summary of the training program's content. 3. In-service training shall include: a. Policies regarding the responsibilities of specific job duties; b. Services provided by the facility; c. Recordkeeping procedures; d. Procedures for the reporting of cases of adult abuse, neglect, or exploitation pursuant to KRS 209.030; e. Resident rights established by KRS 216.510 through 216.525; f. Adult learning principles and methods for assisting residents to achieve maximum abilities in ADLs and IADLs; g. Procedures for the proper application of emergency manual restraints;	P 120	P120 902 KAR 20:036 4 (10)(h) We have a high rate of turn over in staff/caregivers at the facility. This makes training a challenge at times. Based on a review of our documentation post audit, and in my conversation with Gayle and Brian, I have added an "Onboard Training" observation notes sheet. I have attached this sheet, Along with our Inservice Record sheet that was currently in use. We will be using this sheet effective at once. I have attached a copy of both sheets for the record.	10/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/11/25

STATE FORM [illegible] — If continuation sheet 1 of 12

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P 120	Continued From page 1	P 120	P120	

h. Procedures for maintaining a clean, healthful, and pleasant environment;
i. The aging process;
j. The emotional problems of illness;
k. Use of medication; and
l. Therapeutic diets.
4. Each SPCH shall ensure that at least one (1) direct care staff member in addition to the administrator completes the mental illness or intellectual disability training workshop established by 921 KAR 2:015, Section 14, within six (6) months of hire and every two (2) years thereafter. An SPCH shall employ at least one (1) direct care staff member who has received the training.

This LEVEL A is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, the facility failed to educate staff on Bloodborne Pathogens for 4 of 6 sampled employees, Caregiver (C) 1, C2, C3, and Head of Medications/Head of Dietary.

The findings include:

Review of the facility's policy titled, "Inservice Training," not dated, revealed inservice training shall include but not be limited to the following: Bloodborne Pathogens.

1. Review of C1's employee file revealed she was

CNA1-Trainings included for Blood-Borne Pathogen, Universal Precautions, HIPPA, Safety Precautions, Attendant Care, DAIL/Elder Abuse

C1- Trainings included for Blood-Borne Pathogens, Universal Safety Precautions, HIPPA, Safety Precautions, Attendant Care, DAIL/Elder Abuse

C2- Quit/No Call-No Show on 10/19/2025, she did not receive the training completed on 10/20/2025

C3- Trainings included for Blood-Bourne pathogens, Universal Safety Precautions, HIPPA, Safety Precautions, Attendant Care, DAIL/Elder abuse

S. Lucas – Trainings included for Blood-Bourne Pathogens, Universal Safety Precautions, HIPPA, Safety Precautions, Attendant Care, DAIL/Elder Abuse

10/24/2025

902 KAR 20:036 4 (10)(h)

I have also implemented, with my Administrator in my Absence, a chronological list for Inservice Training with Staff. This list with serve as a guide for myself and my other Admin to administer as we navigate through training to build layers of education throughout the caregiver's employment at the care home facility.

10/24/2025

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P 120	Continued From page 2 hired on 11/25/2024, but there was no education/training documented about preventing the spread of bloodborne pathogens or Universal Precautions Safety Training. During interview with Caregiver (C) 1 on 10/14/2025 at 3:51 PM, she stated her training was on the facility's routines. She stated she was instructed on medication administration and then observed it. For a glucose check, she stated she was taught to put on gloves, open the glucose meter (glucometer), remove the old needle, put in a fresh needle, turn on the glucometer, do the test, document the results, and put the glucometer back into the case. 2. Review of C2's employee file revealed she was hired on 07/29/2025, but there was no education/training documented. 3. Review of C3's employee file revealed he was hired on 09/17/2025, but there was no education/training documented. 4. Review of Head of Medications/Head of Dietary's employee file revealed she was hired on 09/04/2024. Further review revealed she did not receive education/training in Universal Safety until 07/07/2025; Medication Management until 08/07/2025; and Bloodborne Pathogens until 06/23/2025. During an interview with the Administrator on 10/16/2025 at 2:15 PM, she stated the process for training staff was to go through a one-on-one when staff was at the facility. She stated if there was not enough staff, she informally went through the process, and the training was verbal. She stated one staff would administer medication, and the new staff would observe. Then, she stated the	P 120	P120 902 KAR 20:036 I am developing a step-by-step guideline for Caregivers for the Medication Administration Process. This will clear up any confusion or misunderstanding during the training process. Once the staff is complete and compliant in the medication administration process, the trainer will sign off on the medication administration education sheet. This sheet will be amended and/or adapted for any new residents admitted to the facility that have independent specific needs regarding medications or processes that require special attention in the medication process. This step-by-step guide will also be found as a reference in the medication room.	12/01/25

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P 120	Continued From page 3 new staff would do the medication administration, and the person training would observe. She stated all staff education was documented in the employee file. She stated the files that did not have education documented was because those employees had just started working at the facility.	P 120		
P 210	902 KAR 20:036 5(1)(a) Section 5. Provision of Services Section 5. Provision of Services. (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to ensure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide basic health services concerning infection control for 3 of 12 residents observed during medication administration and a glucose check, Resident (R) 1, R3, and R5.	P 210	P210 90 KAR 20:036 5(1)(a) Section 5. All staff received education on proper hand hygiene & glove use on 10/20/2024. We do not use agency staff at the facility. The Administrator did this training. There will also be an education sign off sheet on Glucose checks. This guide will serve as a step-by-step guideline for Caregivers engaged in the Medication Administration Process.This will clear up any confusion or misunderstanding during the training process. This is a training process that will be provided to all new hires during the training process along with the Universal Safety Precautions, Safety Precautions, and Blood-Borne Pathogen Education. New hired staff going through the Medication administration Process and Glucose Monitoring checks will need to be monitored by Admin for a sign off to execute independently. Observational Audits will be repeated quarterly.	12/01/25

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P 210	Continued From page 4	P 210		

The findings include:

Observation on 10/14/2025 at 8:59 AM revealed Certified Nurse Aide (CNA) 1 performed a glucose check on Resident (R) 5 without wearing gloves. Continued observation revealed she then gave medications to R3, but she did not sanitize or wash her hands after the glucometer check.

Observation on 10/15/2025 at 8:45 AM revealed CNA1 put on gloves and administered medications to R15 and R16. Then, wearing the same gloves, she took R1's glucometer out of the case, and R1 completed his glucose check. CNA1 then held the trash receptacle up to R1, and he threw the test strip in it.

During an interview with CNA1 on 10/14/2025 at 9:16 AM, she stated she had received online infection control training in 2023, but she had not received training in infection control at this facility. She stated she did not wear gloves during the glucose check because she did not have any gloves.

During interview with Caregiver (C) 1 on 10/14/2025 at 3:51 PM, she stated for a glucose check, she was taught to put on gloves, open the glucose meter (glucometer), remove the old needle, put in a fresh needle, turn on the glucometer, do the test, document the results, and put the glucometer back into the case.

During an interview with the Administrator on 10/16/2025 at 2:15 PM, she stated the process for training staff was for a current staff member to train the new staff. She stated if there was not enough staff, she informally went through the process, and the training was verbal. For

P210

Once the staff is complete and compliant in the Glucose Monitoring process the Admin will sign off on the glucose education sheet.

This sheet will be amended and/or adapted for any new residents admitted to the facility that have independent specific needs regarding glucose checks or insulin that require special attention in the medication process.

This step-by-step guide will also be found as a reference in the medication room.

This reference will also include additional glucocorticoid monitoring education along with response information for a glucose emergency.

If staff is found deficient, the training process will need to be repeated with Head of Medical or Administrator.

12/01/25

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P 210	Continued From page 5 example, she stated one staff would administer medication, and the new staff would observe. Then, she stated the new staff would do the medication administration, and the person training would observe.	P 210		
P 320	902 KAR 20:036 5(3)(b)1 Section 5. Provision of Services Section 5. Provision of Services. (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (b) Housekeeping and maintenance services. 1. A PCH or SPCH shall: a. Maintain a clean and safe facility free of unpleasant odors; and b. Ensure that odors are eliminated at their source by prompt and thorough cleaning of commodes, urinals, bedpans, and other sources. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain a clean and safe environment free of unpleasant odors. Observation on 10/14/2025 and 10/15/2025 of the men's shower room revealed broken floor tiles, with dark staining between the tiles along the wall, orange/brown staining in the shower, and the room was consistently malodorous even after staff cleaning. Additionally, the women's bathroom was observed on 10/14/2025 and	P 320	P320 902 KAR 20:036 5(3)(b)1 Section 5. There has been an improvement process to all the restrooms at the facility reflecting on multiple observations of destruction with special attention to individuals with mental illness. We have made a special effort to increase durability in flooring and fixtures while staying with in a budget. There were 3 complete overhauls of 2 full and 1 half baths with a partial revamp to our handicapped facility. This project was temporarily stopped due to a complication on the contractor's end. The project is currently getting back on track with a projected completion by the end of January or mid-February bearing no complications.	2/15/2026

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P 320	Continued From page 6 10/15/2025 without a soap dispenser or soap. The findings include: Observation on 10/14/2025 at 8:10 AM revealed the women's bathroom had a place for a soap dispenser but had no soap dispenser on the wall and had no soap available in the bathroom. Observation on 10/14/2025 at 8:22 AM revealed the men's shower room was malodorous, with odor evident from out in the hallway outside of the shower room. The floor tiles were dark in color and broken, with dark brown staining between the tiles. The raised toilet seat was covered in urine. Around the base of the cream-colored shower were orange-brown stains. Further observation revealed, across the hall, the men's bathroom had an "out of order" sign on it. The door did not have a lock on it, and inside, much of the floor was missing, with a mattress and a plywood sheet standing up against the sink. Observation on 10/15/2025 at 8:05 AM revealed the women's bathroom remained empty of soap or the soap dispenser. The men's shower room remained malodorous and dirty-looking, with staining between tiles and orange-brown staining around the base of the shower. In an interview with Manager (M) 1 on 10/15/2025 at 2:32 PM, she stated she had cleaned the bathrooms today, and Caregiver 2 was in process of doing so now. She stated soap dispensers in bathrooms were filled half full, as residents saw how much they could use each time. She stated hand sanitizer was in use until a resident started drinking it. She stated the Owner was aware the soap dispenser in the women's bathroom was down, and he would be coming to fix it. M1 stated	P 320	P320 We are halfway through another half bath and will then turn our attention to the last full bath. This is the bath in question, as it will require us to completely tear up the floor and replace with the more secure choice that we have chosen for the earlier remodels. Regarding soap dispensers, we will replace/rehang current dispenser. Due to the residents being very destructive, we may transition to another choice, for example, simply having residents pick up shampoo/body-wash when they pick up towels for showers. Some residents have chosen to keep their own bar soaps in their own personal individual containers in their rooms. Maintenance observations and/or inspections will be done quarterly (every 90 days) for repairs needed. Other small repairs such as, soap dispensers, covers, seats, covers, et cetera, will be as needed and as soon as possible if parts need to be ordered for the repair.	2/15/2026 12/1/2025 12/1/2025

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P 320	Continued From page 7 a lot of stuff got broken, and staff tried to keep up with fixing it. When asked about the men's shower room, M1 stated staff had scrubbed the toilet and the floor, and they were not able to get rid of the smell. She stated several male residents were not careful and urinated on the floor, making it hard to keep bathrooms clean. In an interview with Caregiver (C) 2 on 10/15/2025 at 3:18 PM, she stated part of her job was cleaning bathrooms. She stated she worked 2:00 PM until 10:00 PM and felt like she had the right supplies for cleaning the bathrooms and was able to get them clean. She stated she used magic erasers on the showers and scrubbed the floor when she came to work and after dinner. She stated she tried her best to keep the facility clean for the residents. She stated some staining could not be removed, and even after she had cleaned the men's shower room, the odor was still there. In an interview with Resident (R) 3 on 10/15/2025 at 3:37 PM, he stated currently men had one bathroom, and women had two bathrooms, as one of the men's bathrooms was being remodeled. He stated there were 20 men and seven women, and sometimes it could be difficult to find a bathroom to use, especially when residents were showering in the bathrooms with showers (shower rooms). R3 stated staff frequently cleaned the bathrooms, using a scrub brush and mop. He stated bathrooms got cleaned at least three times each shift. In an interview with R1 on 10/16/2025 at 8:39 AM, he stated men currently had one bathroom, and women had two. He stated sometimes if someone was taking a shower, staff would allow men to use the women's bathrooms. He stated	P 320	This is an ongoing struggle in production, as currently it has been extremely difficult to keep a productive contractor. We have a back up plan in place, post the local flood which halted/impeded construction. Our plan is to have the current remodel complete, and the last bathroom completed by the first of the new year. We will then productively repair/replace as needed for repairs.	2/15/2026
			Maintenance observations and/or inspections will be done quarterly (every 90 days) for repairs needed. Other small repairs such as, soap dispensers, covers, seats, covers, et cetera, will be as needed and as soon as possible if parts need to be ordered for the repair.	12/1/2025

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P 320	Continued From page 8 the other men's bathroom had to be fixed, and it had been out of order for about two to three months. In an interview with the Administrator on 10/16/2025 at 1:48 PM, she stated it was her expectation the bathrooms be kept clean for resident use. She stated on the end of the hall with the women's bathroom and shower room, they found the wood underneath would hold odors, so that was removed and new flooring was installed. She stated she believed that would have to be done with the men's end of the hall as well. She stated the Owner worked on addressing one bathroom at a time, as staff wanted to make sure there were enough bathrooms opened to residents during remodeling.	P 320		
P 355	902 KAR 20:036 5(3)(c)4 Section 5. Provision of Services Section 5. Provision of Services. (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (c) Dietary services. 4. Food preparation and storage. a. There shall be at least a three (3) day supply of food to prepare well-balanced, palatable meals. b. Food shall be prepared with consideration for any individual dietary requirement. c. Modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician. d. At least three (3) meals per day shall be served with not more than a fifteen (15) hour span between the evening meal and breakfast. e. Between-meal snacks, including an evening snack before bedtime, shall be offered to all	P 355	P355 902 KAR 20:036 5(3)(c)4 Section 5. Our Dietary Manager recently was on maternity leave. As a result, another employee was stepped up to cover dietary for the facility. As our Dietary manager returned, the current procedure to check temperatures upon arrival obviously failed.	10/24/2025

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P 355	Continued From page 9 residents. f. Adjustments shall be made if medically contraindicated. g. Food shall be: (i) Prepared by methods that conserve nutritive value, flavor, and appearance; and (ii) Served at the proper temperature and in a form to meet individual needs. h. A file of tested recipes, adjusted to appropriate yield, shall be maintained. i. Food shall be cut, chopped, or ground to meet individual needs. j. If a resident refuses food served, substitutes shall be offered. k. All opened containers or leftover food items shall be covered and dated when refrigerated. l. Ice water shall be readily available to the residents at all times. m. Food services shall be provided in accordance with 902 KAR 45:005. This requirement is not met as evidenced by: Based on observation, interview, and record	P 355	P355 This was immediately fixed and corrected. The staff member brought the oversight to my attention, and a discussion took place regarding food safety. As a result of the missed temperature check, we have amended our procedure. Starting at once, our Dietary Manager will check temperatures first thing in the morning and review again prior to lunch. Staff on third shift will also do an evening check on temperatures, as in the past on 2 occasions we have caught a temperature flux in the freezer and responded accordingly to maintain proper food storage. This procedure was covered with all staff. Temperatures will be checked and recorded in the mornings and reviewed in the afternoon and evening again for safety purposes.	10/24/25 10/24/25 10/24/25

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P 355	Continued From page 10 review, the facility failed to ensure food items were stored at the proper temperature to ensure food safety. Observation on 10/14/2025 revealed a stand-up refrigerator and freezer in the food storage room with a daily temperature log posted on the stand-up refrigerator. However, review of the daily temperature log revealed there were no temperatures documented after 09/28/2025. The findings include: Observation of the food storage room on 10/14/2025 at 8:45 AM revealed a daily monitoring of temperatures posted on the stand-up refrigerator, recording daily temperatures for the stand-up refrigerator and floor freezer located in the food storage room. Review of the daily temperature recordings for the stand-up refrigerator and floor freezer revealed they were last recorded on 09/28/2025. In an interview with Manager (M) 1 on 10/15/2025 at 2:32 PM, she stated she was responsible for recording temperatures and changing the temperature log sheets each month. She stated she forgot to change the temperature log in the food storage room. She stated it was important to document food storage temperatures, as fluctuations could lead to spoiled food or salmonella growth, and she would not want residents to get sick. In an interview with the Administrator on 10/16/2025 at 1:48 PM, she stated it was important to check storage temperatures for food safety. She stated the staff was usually good about checking food storage temperatures first thing in the morning. She stated, in the past, staff had noticed a problem with the freezer, and they	P 355	P355 Any discrepancies or perceived problems will be reported immediately to the Administrator. 10/24/25 This has never been an issue in the past. I believe the change in staff resulted in this oversight. Since the immediate change in procedure there has been no other occurrences regarding temperature records. 10/24/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100361	A. BUILDING: _____ B. WING _____	C 10/16/2025

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P 355	Continued From page 11 were able to get it replaced. She stated the facility had to throw out food in the past as a result of issues with food storage.	P 355		

Office of Inspector General

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	100381	A. BUILDING: _____ B. WING _____	C 10/16/2025

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B 100	902 KAR 20:205 5(3)(a-c) SECTION 5. ANNUAL TB RISK ASSESSMENTS & TESTS (3) The requirements established in this subsection shall apply during annual TB testing. (a) A health care setting shall use staggered tuberculosis testing to assure that all health care workers are not tested in the same month. Staggered testing shall be performed monthly, quarterly, or semiannually. (b) A health care worker who has worked eleven (11) months or more in the facility and who has never had a TST interpreted as positive, or has never had a positive BAMT, shall have a TB Risk Assessment and a TST or BAMT annually in or before the same month as the anniversary date of his or her last TB Risk Assessment and TST or BAMT. (c) A health care worker who has worked eleven (11) months or more in the facility and who has had a previous TST interpreted as positive, or a previously positive BAMT, shall: 1. Have an annual TB Risk Assessment in or before the same month as the anniversary date of his or her last TB Risk Assessment; and 2. Not be required to submit to an annual TST or BAMT.	B 100	B 100 902 KAR 20:205 5(3) (a-c) Section 5. It is an ongoing problem with the revolution of staff/caregivers at the facility and getting a timely TB Skin Test completed. I am currently sending all employees to the local health department for the test. This year there was a hope that the health department would come to the facility and do not only all staff but all residents as well. Per the health department, this was not a request that could be met due to a billing issue with residents and staff. I promptly advised all current employed staff to get their TB Skin test requirement fulfilled which they all did promptly. I have attached all forms.	10/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/11/25

Office of Inspector General

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B 100	Continued From page 1 This requirement is not met as evidenced by: Based on interview, employee record review, and review of the facility's policy, the facility failed to ensure staff had a Tuberculin (TB) skin test documented in the employee's personnel record within the first month of employment for 4 of 5 sampled employees, Caregiver (C) 1, C2, C3, and Certified Nurse Aide 1. The findings include: Review of the facility's policy titled, "Tuberculin Skin Testing of Staff," not dated, revealed a skin test shall be initiated on all new staff members before or during the first week of employment, and the results shall be documented in the employee's personnel record within the first month of employment. 1. Review of Caregiver (C) 1's personnel record revealed a date-of-hire of 11/25/2024; however, there was no documented TB skin test in the record. 2. Review of C2's personnel record revealed a date-of-hire of 07/29/2025; however, there was no documented TB skin test in the record. 3. Review of C3's personnel record revealed a date-of-hire of 09/17/2025; however, there was no documented TB skin test in the record. 4. Review of Certified Nurse Aide 1's personnel record revealed a date-of-hire of 08/19/2025; however, there was no documented TB skin test in the record. During an interview with the Administrator on 10/16/2025 at 2:15 PM, she stated staff usually	B 100	8100 Admin – Included completed 10/30/2025 CNA1 – Included completed 11/5/2025 C1- Included completed 11/5/2025 C2 – Quit/ No call-No show 10/19/2025 C3- Included completed 11/19/2025 Stephanie – (not requested) included completed 11/5/2025	10/27/25

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B 100	Continued From page 2 did not stay long in employment at the facility, and that was the reason they did not get a TB skin test within the first week of employment. She stated Caregiver 1 had a TB skin test and was unable to have it read, so she was going to reschedule the test.	B 100		