Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100050	A. BUILDING: _____ B. WING _____	R-C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOMES I LLC	219 STEVENS AVENUE PRINCETON, KY 42445

(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 upon review of the acceptable Plan of Correction (PoC), the facility was deemed to be in compliance on 10/29/2025, as alleged.	(P 000)		

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

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	100050	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOMES I LLC	219 STEVENS AVENUE PRINCETON, KY 42445

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P 210	Continued From page 1 This requirement is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure resident(s) were appropriately supervised and monitored for infectious disease to ensure healthcare needs were met and to provide basic health and health related services for one of five sampled residents, R2. The findings include: Review of facility policy on 09/26/2025, titled, "Infection Control Policy," undated, revealed it is the policy of the facility to stop the spread of any infection that may break out in the facility. Review of Resident (R) #2's record revealed the facility admitted him in June of 2017 with the diagnoses of schizophrenia and a history of positive tuberculosis (TB) skin test. He received a chest x-ray on 09/04/2025 and it showed signs of tuberculosis according to his primary care provider. The primary care provider suggested that R2 wear a mask while out of his room and for him to stay in his room as much as possible to protect other residents and staff. At that time, he was seen by the nurse practioner to be referred to a pulmonologist in another facility but R2 refused. She also recommended staff wear masks for protection as well and staff are not wearing masks. R2 remained in the facility without a plan for movement to a sustained higher level of care to ensure appropriate medical treatment required for potentially infectious tuberculosis Resident was noted by this investigator to be walking around the facility without a mask on	P 210	Administrator in-serviced All staff on 09/30/2025 of the importance of following the medical providers orders of wearing masks when a possible infectious Resident is in the building. In making sure all TB policy and Procedures are being met, the Assistant Administrator will view all Resident charts and employee files to make sure all TB shots are up to date. In the event that a Resident has a possible positive TB skin test reading, it will be the responsibility of the administrator to notify the appropriate officials of the positive reading.. It is the duty of the Administrator to make sure the Positive Resident gets the medical treatment needed. No Resident will be allowed back into the facility until the Resident has a negative TB result. The administrator and Assistant Administrator will supervise and monitor all Residents and staff for infectious disease to ensure healthcare needs are met and to provide basic health and health related services.	

10/31/25 Candi Crocker admin

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P 000	Initial Comments A Complaint Survey was concluded on 09/26/2025. The facility was found not to be in substantial compliance. No deficiencies were issued related to KY00047272. There were deficiencies cited related to KY00047307. Survey Date: 09/26/2025 Survey Census: 40 Sample Size: 5 Supplemental Residents: 0	P 000	Highland Homes P230 Provision of Services Basic Health and Health Related Services' When admitting a new Resident is the policy of the facility to ensure the New admit has a TB skin test upon admission. It is also the policy of the facility to monitor charts to make sure all Residents and staff are up to date with the TB skin test or a chest x-ray. Administrator in-serviced staff on TB skin testing protocols,infectious disease, policy and procedures on 09/30/2025.	
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	P 210		

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P 210	Continued From page 2 09/28/2025. Observation on 09/26/2025 at 9.15 AM by this investigator revealed R2 sitting outside in the parking lot smoking. He did not have a mask at that time. Tour of facility on 09/26/2025 at 9:30 AM and 2:45 PM revealed no staff or other residents wearing masks. Observation by this investigator of R2 in front hallway on 09/26/2025 at 10:30 AM revealed him without a mask. He stated he was not contagious and does not have TB. He stated he had cancer and that it was not contagious. Interview with complainant on 09/26/2025 at 10:15 AM who is a nurse with the local health department assigned to the case of R2 revealed that she stated that R2 had not been cleared of having active tuberculosis at that time. She stated she was not aware of him going to the hospital on 09/19/2025. She stated he was required to have three (3) negative sputum smears or two (2) negative polymerase chain reaction (PCR) tests eight (8) to twenty-four (24) hours apart to rule out infectiousness. Once these tests are performed and he is cleared, he may be back around other residents and staff without restrictions. She went on to say he should not be exposed to other residents or staff without a mask. Interview with R2's guardian on 09/26/2025 at 1:58 PM revealed she stated she was contacted on 08/26/2025 by the facility's Advanced Practice Registered Nurse (APRN) and that she suspected R2 of possibly having tuberculosis. She stated she was informed the facility needed	P 210	To ensure that protocols are being followed the administrator and Asst. administrator monitored all Resident charts for 2 months, checking that All Residents are up to date to date on their TB test. The monitoring began on 9/28/2025 and has an end date of 10/29/2025. R2 was medically cleared and ruled out that he did not have a positive ready for TB. R2 was able to return to the facility once the facility received the results of the negative TB reading.	

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P 210	Continued From page 3	P 210		

to keep him in his room, and for him to wear a mask when he was out in the common areas. She was told on this date also that he had lost 10 pounds in a week and was not feeling well with a cough. She stated that R2 refused to stay in his room and to wear his mask all the time. She goes on to say she feels like the staff did everything they could to see that he followed the instructions of the APRN.

Interview with the facility Advanced Practice Registered Nurse on 09/26/2025 at 12:26 PM, revealed she stated when she suspected R2 of tuberculosis symptoms, which included a positive Tuberculosis QuantiFERON (TB Gold Plus Test), cough, weight loss, and not feeling well, she recommended him to be sent to a hospital for further evaluation. She went on to say that R2 had refused to go for any sort of treatment at the time. She recommended to R2 and the facility administrator for him to be in a private room and for him to wear a mask when out of his room as well as the staff to wear masks. She stated she does not know why the staff did not follow her recommendations for wearing masks. She stated the importance of that was to make sure he did not spread tuberculosis to other residents and staff.

Interview with Nurse Aide #1 on 09/26/2025 at 10:15 AM revealed she was not wearing a mask. She stated she did not know she was supposed to wear a mask due to R2 having tuberculosis.

Interview with the Assistant Administrator on 09/26/2025 at 2:30 PM revealed she stated that R2 had a positive tuberculosis result in the past. She stated that she noticed a change in R2 in the last couple of weeks and that he was more tired than usual. She stated she encouraged him to

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P 210	Continued From page 4	P 210		

see a physician and he did agree to a chest x-ray. After the results were given to her by the APRN, she stated they were instructed by her to send him to a hospital for evaluation. She went on to say that they called an ambulance to transport him, but he refused all care. She stated he wore his mask on and off since then. She stated on 09/19/2025 at approximately 4:00 PM, R2 came to her and asked her to take him to the local hospital. She transported him to the local hospital, and he was left there to be evaluated. After several hours of evaluation, R2 was found to have a large mass in his lung that was suspicious of being cancer. They could not completely rule out tuberculosis without further testing. The hospital recommended R2 being transferred to another hospital for evaluation, but R2 refused. He was then brought back to the facility by the Administrator at 3:00AM on 09/20/2025. The facility knew that R2 was an infectious disease risk and in the days following the event on 09/19/2025, did not take appropriate steps by ensuring that he was moved to a sustained higher level of care required to meet his healthcare needs. The continued exposure by R2 after the Administrator returned R2 to the facility from the hospital put the staff and other residents at infectious diease transmission risk.

Interview with Administrator on 09/26/2025 at 2:30 PM revealed, she stated the first of September, she was made aware that R2's tuberculosis test that was ordered by the APRN came back positive. She stated she knew he was positive in the past. She believes that R2 took medication for tuberculosis, but she is not sure. She stated she knew how serious it was for the other residents and staff if R2 had active tuberculosis. She went on to say that the APRN wanted her to keep R2 in a private room and

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HIGHLAND HOMES I LLC	210 STEVENS AVENUE PRINCETON, KY 42445

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P 210	Continued From page 5 have him wear a mask when he came out in the hallway. She stated the APRN instructed her that her staff needed to wear masks for protection as well. She stated she told her staff to wear the masks. but they would not. The administrator was not wearing a mask and could not give a reason as to why she did not follow the recommendation. The staff did not wear masks as ordered by the provider and in doing so failed to provide the services ordered by the resident's health care practitioner. She stated they had tried everything they could to get R2 to the hospital for evaluation, but he would not comply.	P 210		

10/9/25 Carla Crocker admin

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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.	P 210		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/31/25

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P 210	Continued From page 1	P 210		

This requirement is not met as evidenced by:
Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure resident(s) were appropriately supervised and monitored for infectious disease to ensure healthcare needs were met and to provide basic health and health related services for one of five sampled residents, R2.

The findings include:

Review of facility policy on 09/26/2025, titled, "Infection Control Policy," undated, revealed it is the policy of the facility to stop the spread of any infection that may break out in the facility.

Review of Resident (R) #2's record revealed the facility admitted him in June of 2017 with the diagnoses of schizophrenia and a history of positive tuberculosis (TB) skin test. He received a chest x-ray on 09/04/2025 and it showed signs of tuberculosis according to his primary care provider. The primary care provider suggested that R2 wear a mask while out of his room and for him to stay in his room as much as possible to protect other residents and staff. At that time, he was seen by the nurse practioner to be referred to a pulmonologist in another facility but R2 refused. She also recommended staff wear masks for protection as well and staff are not wearing masks. R2 remained in the facility without a plan for movement to a sustained higher level of care to ensure appropriate medical treatment required for potentially infectious tuberculosis.

Resident was noted by this investigator to be walking around the facility without a mask on

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P 210	Continued From page 2	P 210		

09/26/2025.

Observation on 09/26/2025 at 9:15 AM by this investigator revealed R2 sitting outside in the parking lot smoking. He did not have a mask at that time.

Tour of facility on 09/26/2025 at 9:30 AM and 2:45 PM revealed no staff or other residents wearing masks.

Observation by this investigator of R2 in front hallway on 09/26/2025 at 10:30 AM revealed him without a mask. He stated he was not contagious and does not have TB. He stated he had cancer and that it was not contagious.

Interview with complainant on 09/26/2025 at 10:15 AM who is a nurse with the local health department assigned to the case of R2 revealed that she stated that R2 had not been cleared of having active tuberculosis at that time. She stated she was not aware of him going to the hospital on 09/19/2025. She stated he was required to have three (3) negative sputum smears or two (2) negative polymerase chain reaction (PCR) tests eight (8) to twenty-four (24) hours apart to rule out infectiousness. Once these tests are performed and he is cleared, he may be back around other residents and staff without restrictions. She went on to say he should not be exposed to other residents or staff without a mask.

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P 210	Continued From page 3	P 210		

to keep him in his room, and for him to wear a mask when he was out in the common areas. She was told on this date also that he had lost 10 pounds in a week and was not feeling well with a cough. She stated that R2 refused to stay in his room and to wear his mask all the time. She goes on to say she feels like the staff did everything they could to see that he followed the instructions of the APRN.

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Interview with Administrator on 09/26/2025 at 2:30 PM revealed, she stated the first of September, she was made aware that R2's tuberculosis test that was ordered by the APRN came back positive. She stated she knew he was positive in the past. She believes that R2 took medication for tuberculosis, but she is not sure. She stated she knew how serious it was for the other residents and staff if R2 had active tuberculosis. She went on to say that the APRN wanted her to keep R2 in a private room and

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