

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 02/10/2016
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504		
(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS  An offsite revisit survey was conducted and based on the facility's acceptable plan of correction, the facility was deemed to be in compliance as alleged on 01/23/16.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2016  
FORM APPROVE  
OMB NO. 0938-009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/13/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 VERSAILLES ROAD LEXINGTON, KY 40504
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(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)	CS COMPLETION DATE
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<p>F 000 INITIAL COMMENTS</p> <p>AMENDED</p> <p>An Abbreviated Survey investigating Complaint KY#00024035 was initiated on 11/12/15 and concluded on 11/13/15. Complaint KY#00024035 was substantiated with related deficiencies cited.</p> <p>F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) SS=E INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	<p>F 000</p> <p>F 225</p> <p>Investigation</p> <p>The allegation of abuse was received on 10/31/2015 at approximately 0645. The nurse receiving the report from the resident reported it to the house supervisor around 0700. The house supervisor called the Chief Nursing Officer at approximately 0730. The complaint was against an SRNA who was contract staff. His shift was over for the night. The agency was called to advise that he could not return to the facility. The staffing office at the hospital was advised he could not work at Cardinal Hill. All residents on the unit were assessed at approximately 0700. Resident 1, A, B, &amp; C received assessments including pain, skin assessments, mood, &amp; behavior. No issues were noted other than those already present. No injuries were noted at that time nor at any time thereafter. No mental health issues were noted on 10/31 nor at any time thereafter.</p>	<p>January 22, 2016</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE 1/29/16

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2017  
FORM APPROVED  
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X-1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	X2: MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	X3: DATE SURVEY COMPLETED  C 11/13/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 VERSAILLES ROAD LEXINGTON, KY 40504
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X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY!	DATE
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F 225 Continued From page 1  
representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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 have an effective system to ensure allegations of abuse were thoroughly investigated for one (1) of six (6) sampled residents (Resident #1) and three (3) unsampled residents (Unsampled Residents A, B, and C)

On 10/31/15, at approximately 6:30 AM, Licensed Practical Nurse (LPN) #3 received allegations of abuse while conducting her medication pass. Unsampled Resident C complained State Registered Nurse Assistant (SRNA) #1 ran his fingers down his/her leg scraping the leg, and it scared him/her. Resident #1 complained the night shift aide was "rough, so rough, he was just rough". Although LPN #3 called the House Supervisor and was told to put the concerns in writing, there was no documented evidence of an initial investigation conducted to include examining the residents for potential injuries. In addition, there was no documented evidence of interviewing other residents on the floor to find out if there was further allegations of abuse until 11/02/15, two (2) days later. On 11/02/15, the facility interviewed other residents, and Unsampled Resident A complained of SRNA #1 fondling himself on the outside of his scrubs and was concerned the SRNA would do something to

F 225 The Chief Nursing Officer came to the facility on 10/31/15. She was aware of prior actions. No resident injury was noted. The alleged offender was not on site and had been barred from the facility. The Chief Nursing Officer was covering for the Administrator over the weekend. The safety of all residents had been ensured at that time. The Chief Nursing Officer filed the self report with the OIG on 10/31. No one was in the office, thus a message was left on the voice mail for the Regional Program Manager. Adult Protective Services was notified on 10/31 via email that was confirmed in writing. The nurse who received the allegation completed her written statement on 10/31. There were no witnesses to the alleged event. No other witnesses were noted or referred to by residents at the time of interviews.

The House Administrators for the weekend were apprised of the event and were aware of the banned status of the agency employee and the resident concern.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVE  
OMB NO. 0938-038

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	21 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155467	Y21 MULTIPLE CONSTRUCTION - BUILDING _____  - (JMO) _____	X1 DATE SURVEY COMPLETED  C 11/13/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL		STREET ADDRESS CITY STATE ZIP CODE 3050 VERSAILLES ROAD LEXINGTON, KY 40504	
X41 D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	E PREFIX TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 225 Continued From page 2  
ner/him sexually, and Unsampled Resident B complained SRNA #1 made the resident feel "creeped out"

The findings include

Review of the facility policy, titled Abuse Prevention and Reporting, effective 05/01/15, revealed reports of alleged abuse to patients from other patients, volunteers, staff or other agencies serving the individuals, family members, legal guardians, friends, other individuals, or identified injunes of unknown origin would be immediately reported to the facility Administrator/designee Per the policy, the Administrator/designee would immediately and thoroughly investigate the alleged violations or injuries. Continued review revealed, upon receiving reports of physical or sexual abuse, the supervising nurse shall immediately examine the patient with the findings of the examination recorded in the patient's medical record and on abuse investigation forms An immediate investigation would be made and a copy of the findings would be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 10/17/15 with diagnoses to include Right Hip Fracture, History of Cerebral Vascular Accident (CVA), and Hypertension. Review of Resident #1's Brief Interview for Mental Status (BIMS) conducted on 10/31/15, revealed a score of fourteen (14) out of fifteen (15) indicating no cognitive impairment.

Review of Licensed Practical Nurse (LPN) #3's typewritten statement, dated 10/31/15, revealed

F 225 On November 2, 2015, the Chief Nursing Officer advised the Administrator of the event upon his return to the facility. She again advised the responsible agency of the request for the contractor to not return to the facility. This communication was made to the staffing manager at the agency & was referred to in the Five Day Report. The contractor was placed on the Do Not Return List for the hospital to ensure communication at Cardinal Hill with all staff who work with scheduling going forward. The agency had completed the abuse registry check and abuse education per requirements. Copies were provided by the Agency and to the surveyor.

The Nursing Director interviewed all residents on the wing where the contractor worked. She interviewed additional nursing staff to gather further information. No further action was required consistent with the investigational findings. No injuries were noted on any resident at that time nor at any time since the investigation. The contractor was barred from the facility on a permanent basis and that communication had occurred amongst all parties on the day of the event. No evidence indicated that the contractor had been in any other rooms other than those assigned. The ARNP for the Medical Director was apprised of the allegations.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/13/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504	
(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)

F 225 Continued From page 3

Resident #1 told her the night shift aide was "rough, so rough, he was just rough". Per LPN #3's statement, Resident #1 was "grimacing".

2. Review of Unsampled Resident C's medical record revealed the facility admitted the resident on 10/11/15 with diagnoses including Atherosclerotic Heart Disease. Review of Unsampled Resident C's Brief Interview for Mental Status (BIMS) conducted on 10/25/15, revealed a score of fifteen (15) out of fifteen (15) indicating no cognitive impairment.

Review of Licensed Practical Nurse (LPN) #3's typewritten statement, dated 10/31/15, revealed Unsampled Resident C reported, SRNA #1 "went down my leg and scrapped it all the way" and "I really had a funny feeling about this man, like he was not right, and he was not right with me, it scared me".

Interview with LPN #3, on 11/12/15 at 3:45 PM, revealed while passing medications on 10/31/15 at approximately 6:30 AM, Unsampled Resident C complained SRNA #1 "ran his fingers down my leg". LPN #3 further stated she next went to Resident #1's room and asked the resident if everything was okay last night. She stated, Resident #1 told her the night shift aide was "rough, so rough, he was just rough". LPN #3 stated Resident #1 was "grimacing". Further interview with LPN #3, revealed she called the House Supervisor and was told to write a statement. LPN #3 stated SRNA #1 was not escorted out because the night shift was over and he had already left.

On 11/02/15, two (2) days after the initial allegations of abuse, further facility investigation

F 225 The Five Day Report was filed in a timely manner on 11/4/2015 to the OIG. The report summarized the investigation & requested that the OIG place the contractor on the state's abuse registry consistent with instruction from the KBN. Follow up with the agency indicated no other contact by outside agencies occurred; however, the agency confirmed knowledge of the allegation and report to them.

All required background checks & education are established for each employee or contractor working with residents. The Abuse policy applies to each resident in the facility. In addition to the preface in the policy book providing latitude to the Administrator or designee, the Abuse Policy was amended to better reflect the management structure at Cardinal Hill.

Further, the policy was amended to reflect the Administrator/Designee functions. All nursing, therapy, and case managers on the unit received education on the policy clarification. The completion date was January 22, 2016.

All residents identified as having contact or potential contact with an alleged abuser will be interviewed at the time the allegation is made known to the facility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	3. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	4. MULTIPLE CONSTRUCTION A. BUILDING:  B. WING:	5. DATE SURVEY COMPLETED  11/13/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 VERSAILLES ROAD LEXINGTON, KY 40504	

1. ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	2. ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	3. COMPLETION DATE
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F 225 Continued From page 4  
and interviews revealed an additional allegation of abuse by Unsampld Resident A and additional concerns about SRNA #1 by Unsampld Resident B

3. Review of Unsampld Resident A's medical record revealed the facility admitted the resident on 10/27/15 for rehabilitation with diagnoses to include Urinary Tract Infection (UTI) and Diabetes. Review of the Brief Interview for Mental Status (BIMS) conducted on 11/03/15 revealed a score of fifteen (15) out of fifteen (15) indicating no cognitive impairment.

Review of the facility's "Follow up with Investigations from Abuse" document, dated 11/02/15, completed by the DON, revealed Unsampld Resident A reported SRNA #1 "stood by his/her bedside fondling himself on the outside of his scrubs". Unsampld Resident A revealed he/she was very uncomfortable and felt very vulnerable being left with him alone. Unsampld Resident A revealed he/she thought he might do something to him/her sexually.

4. Review of Unsampld Resident B's medical record revealed the facility admitted the resident on 10/25/15 with diagnoses of Left Femoral Popliteal Bypass (a procedure used to treat femoral artery disease performed to bypass the blocked portion of the main artery in the leg using a piece of another blood vessel). Review of the Brief Interview for Mental Status (BIMS) conducted on 10/30/15 revealed a score of fifteen (15) out of fifteen (15) indicating no cognitive impairment.

Continued review of the "Follow up with Investigations from Abuse" document, dated

F 225 Resident #1 is discharged thus, no further action can be taken.

All residents will receive head to toe assessments at least every 12 hours following any allegations of abuse, when residents are identified as being in contact with the alleged abuser. The initial assessment will be done at the time the allegation is made known within a time frame consistent with the residents' exposure risk.

Documentation of the assessments will be made on the nursing resident assessment form. The policy will reflect that the Director of Nursing will assess all potentially affected residents or assign that to another RN on the unit for assessment. The Administrator will receive updates regarding the assessments throughout the five (5) day investigative period & beyond as needed. Physicians will be apprised as appropriate.

All residents are covered under The Abuse Prevention & Reporting Policy.

The investigative process will be initiated consistent with the regulations and be completed by Day 5 with a summary report

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2016  
ALPM APPROVAL  
CMS NO. 2567-02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	3. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  198467	4. MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	5. DATE SURVEY COMPLETED  C 11/13/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL		STREET ADDRESS CITY STATE ZIP CODE 2960 VERSAILLES ROAD LEXINGTON, KY 40504	
6. ICD PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	7. ICD PREFIX TAG	8. PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

F 225 Continued From page 5  
11/02/15, revealed SRNA #1 made Unsampld Resident B feel very uncomfortable and "creeped out".

Additional review of the "Follow up with Investigations from Abuse" document, dated 11/02/15, revealed a further interview with Unsampld Resident C. Per the document Unsampld Resident C reported SRNA #1 was "a creep who was nuts". The document revealed Unsampld Resident C stated she/he was asleep and awoke to him stroking his/her left leg up and down which caused him/her to awaken and literally "scared me to death". Further review revealed Unsampld Resident C said the SRNA wanted him/her to go to the bathroom, so he/she told the SRNA "you never ever touch me like that without introducing yourself and telling me who you are". Per the document, Unsampld Resident C said she got into the bathroom by himself/herself and he watched standing in the bathroom beside him/her fondling himself. The document stated, this upset Unsampld Resident C so bad he/she literally was awake all night scared the SRNA would come back in the room.

Phone interview with the House Supervisor on 11/13/15 at 2:45 PM, revealed no investigation was started other than obtaining the statement from LPN #3 on 10/31/15. The House Supervisor stated SRNA #1 had worked at the facility on another unit previously and there was no complaints related to the SRNA up to this time. The House Supervisor further stated "I did not think he had hit them or anything. LPN #3 explained to me that he had been rough and scary". Further interview revealed LPN #3 did not explain what "rough" meant. The House Supervisor stated she had been trained on Abuse

F 225 or continued, if necessary, until such time as conclusions can be made about the allegations.

The Abuse Prevention and Reporting Policy will reflect the resident assessment procedure, the investigative process & the procedure for informing the Administrator. The revisions were completed on January 22, 2016.

All nsg. staff will be educated regarding the process of assessment, investigation, and reporting by the Director of Nursing. All RN staff will receive training regarding assessment of residents. Documentation will be obtained and maintained with learning objectives and sign in sheets for 100% of unit staff. Education on policy revisions was completed on January 22, 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: 11/03/2015  
FORM APPROVE  
OMB NO. 0938-0045

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

1. MULTIPLE CONSTRUCTION  
FACILITY:

PROVIDER/CLIA  
IDENTIFICATION NUMBER:

085467

BUILDING:

11/03/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CARDINAL HILL REHABILITATION HOSPITAL

2050 VERSAILLES ROAD  
LEXINGTON, KY 40504

LINE  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION:

LINE  
PREFIX  
TAG

PROVIDER'S PLAN OF CORRECTION  
EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY:

LINE  
COMPLETION  
DATE

F 225 Continued From page 6

and she was to document the incident in writing and report the incident to her supervisor who was the Chief Nursing Officer (CNO), and an investigation was done by the CNO or the Administrator. She stated she had contacted the CNO on 10/31/15 early in the morning. The House Supervisor stated "If someone complained they were hurt, I would examine them. She revealed she did not think about the need to assess the residents who complained about SRNA #1 or other residents and did not think about the need to interview additional residents because she did not think anyone was hurt.

Interview with the Director of Nursing (DON), on 11/12/15 at 10:35 AM, revealed she was notified of the incident when she arrived at work on 11/02/15 and immediately she interviewed all of the residents on D Hall where SNRA #1 had worked regarding the concerns related to the care provided by the SRNA #1

Further interview with DON, on 11/13/15 at 3:20 PM, revealed other residents on the floor should have been interviewed prior to 11/02/15. She stated she was not sure if skin assessments were done after the allegations and agreed they should have been completed and documented. The DON stated, on 11/03/15 at 12:00 PM she called the employment agency and reported the final results of her investigation.

Interview with the CNO, on 11/13/15 at 11:00 AM, revealed she was in charge in the absence of the Administrator and the Director of Therapy Operations. The CNO stated she received a phone call on the morning of 10/31/15 about 7:30 AM and she came in to discuss the concerns with the House Supervisor and fulfill her reporting

F 225 The Abuse Prevention and Reporting Policy will reflect the administrative coverages for the unit to include the Administrator and the DON with the CNO covering in the absence of other administrative personnel. The method for notification will be consistent with the timing of the complaint. For example, if the Administrator is on site the communication may be verbal, in person. If off site, it may be via phone, text or other means. Notification to the Administrator or Designee will be made at the time the allegation is made known to the facility.

The Administrator will monitor compliance for each reported allegation. Compliance reports will be made at the monthly Quality meeting. The Quality Committee, in accordance with regulations includes the Administrator, the physician director, the director of the SNF, the Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
CMB NO. 1998-332

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	Y: MULTIPLE CONSTRUCTION - BUILDING _____  - WING _____	INDICATE SURVEY COMPLETED  0 11/13/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2080 VERSAILLES ROAD LEXINGTON, KY 40504		

3.0 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	4. PREFIX TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	5. COMPLETION DATE
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F 225 Continued From page 7  
obligations to the Office of Inspector General and the employment agency in which SRNA #1 worked and they addressed and reported the incident within twenty-four (24) hours. The CNO stated as far as she knew they had followed their Abuse Policy. However, there was no documented evidence a thorough investigation was completed

F 225 of Nursing, and others as appropriate. The Administrator will evaluate each reported event in compliance with the policy.

Resident A is discharged thus, no further action can be taken.

F 225 483.13(c) DEVELOP/IMPLMENT  
SS-E ABUSE/NEGLECT ETC POLICIES

F 225 Resident B is discharged thus, no further action can be taken.

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property

Resident C is discharged thus, no further action can be taken.

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 policies and procedures were implemented related to abuse for one (1) of six (6) sampled residents (Resident #1) and three (3) unsampled residents (Unsampled Residents A, B and C).

F 226 January 22, 2016

On 10/31/15, at approximately 6:30 AM, Licensed Practical Nurse (LPN) #3 received allegations of abuse from residents while conducting her medication pass. Unsampled Resident C alleged State Registered Nurse Assistant (SRNA) #1 ran his fingers down his/her leg scraping the leg, and this scared him/her. Resident #1 alleged the night shift aide was "rough". Although LPN #3 called the House Supervisor and was told to document the concerns in writing, there was no

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/13/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504	
(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)

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documented evidence of an initial investigation conducted to include immediately examining the residents for potential injuries as per policy. In addition, there was no documented evidence of interviewing other residents on the floor to find out if there was further allegations of abuse until 11/02/15, two (2) days later. On 11/02/15, the facility interviewed other residents including Unsampld Resident A who alleged SRNA #1 was fondling himself on the outside of his scrubs and the resident was concerned the SRNA would do something to her/him sexually, and Unsampld Resident B who alleged SRNA #1 made the resident feel "creeped out". In addition, there was no documented evidence the facility had the Social Service's department monitor the residents who were affected as per policy.

The findings include:

Review of the facility policy, titled Abuse Prevention and Reporting, effective 05/01/15, revealed reports of alleged abuse to patients from other patients, volunteers, staff or other agencies serving the individuals, family members, legal guardians, friends, other individuals, or identified injuries of unknown origin would be immediately reported to the facility Administrator/designee. Per the policy, the Administrator/designee would immediately and thoroughly investigate the alleged violations or injuries. Continued review revealed, upon receiving reports of physical or sexual abuse, the supervising nurse shall immediately examine the patient with the findings of the examination recorded in the patient's medical record and on abuse investigation forms. An immediate investigation would be made and a copy of the findings would be provided to the Administrator within twenty-four (24) hours of the

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The Abuse Prevention and Reporting Policy will reflect reporting to the Administrator or covering administration to include the DON and CNO at the time the allegation is made known to the facility. The policy applies to all admitted residents. The policy includes all five criteria noted in the regulations. Revisions were completed by January 22, 2016.

The Abuse Prevention and Reporting Policy will reflect the investigative timeline consistent with the regulations. Reports to the Administrator will be made within the regulatory time frames with full recognition of the management structure/ Administrator designee coverage plan noted in the policy.

Upon assessment of all affected residents, if such assessments reveal, based on the clinician's judgment, that psychological services are needed, the provider will be notified. The provider will order any follow up services deemed necessary which may include social worker assessment, psychology intern assessment, and referral for emergency services.

All residents identified as having contact or potential contact with an alleged abuser will be interviewed at the time the allegation is made known to the facility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2016  
FORM APPROVE  
OMB NO. 0938-005

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	NY PROVIDER-SUPPLIER/CLIA IDENTIFICATION NUMBER:  155487	NO MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETED  11/10/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL	STREET ADDRESS CITY STATE ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504
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YAL 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)	15- COMPLETION DATE
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F 226 Continued From page 9  
occurrence of such incident. Further review revealed, upon receiving information concerning a report of abuse, the Director of Nursing (DON) would request a representative of the Social Service's department monitor the patient's emotional well-being concerning the incident, as well as the patient's relations to his/her involvement in the investigation.

1. Review of Resident #1's clinical record revealed the facility admitted the resident on 10/17/15 with diagnoses to include Right Hip Fracture, History of Cerebral Vascular Accident (CVA) and Hypertension. Review of Resident #1's Brief Interview for Mental Status (BIMS) conducted on 10/31/15, revealed a score of fourteen (14) out of fifteen (15) indicating the resident had no cognitive impairment.

Review of Licensed Practical Nurse (LPN) #3's typewritten statement, dated 10/31/15, revealed Resident #1 told informed her the night shift aide was "rough, so rough, he was just rough". Per LPN #3's statement, Resident #1 was "grimacing".

2. Review of Unsampld Resident C's clinical record revealed the facility admitted the resident on 10/11/15 with diagnoses including Atherosclerotic Heart Disease. Review of Unsampld Resident C's BIMS conducted on 10/25/15, revealed a score of fifteen (15) out of fifteen (15) indicating the resident had no cognitive impairment.

Review of Licensed Practical Nurse (LPN) #3's typewritten statement, dated 10/31/15, revealed Unsampld Resident C stated, SRNA #1 "went down my leg and scrapped it all the way" and "I

F 226 Nursing Staff will be educated regarding the policy changes by the Director of Nursing. Documentation. Education will include learning objectives & sign in sheets for 100% of the unit's nursing staff. Education was completed by January 22, 2016.

The Administrator will monitor all such abuse events for compliance with the policy & report to the Quality Committee on a monthly basis to ensure compliance. The Quality Committee is comprised of the physician director, Administrator, Director of Nursing, Chief Nursing Officer, & other disciplines as appropriate.

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OMB NO. 0938-0392

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	<input type="checkbox"/> MULTIPLE CONSTRUCTION <input type="checkbox"/> BUILDING <input type="checkbox"/> WING <input type="checkbox"/> CAMPUS	DATE SUPPLEMENT LISTED:  11/13/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL	STREET ADDRESS CITY STATE ZIP CODE 3050 VERSAILLES ROAD LEXINGTON, KY 40504
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3.0 D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	3 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	4.0 COMPLETION DATE
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really had a funny feeling about this man, like he was not right, and he was not right with me, it scared me".

Interview with LPN #3, on 11/12/15 at 3:45 PM, revealed while passing medications on 10/31/15 at approximately 6:30 AM, Unsampld Resident C alleged SRNA #1 "ran his fingers down my leg" LPN#3 further stated she then went to Resident #1's room and asked the resident if everything was okay last night. She stated, Resident #1 alleged the night shift aide was "rough, so rough he was just rough". LPN #3 stated Resident #1 was "grimacing". Further interview with LPN #3, revealed she called the House Supervisor and was informed she needed to write a statement. LPN #3 explained SRNA #1 was not escorted out because the night shift was over and he had already left.

On 11/02/15, two (2) days after the initial allegations of abuse, the facility interviewed other residents which revealed an additional allegation of abuse by Unsampld Resident A and additional concerns about SRNA #1 by Unsampld Resident B.

3. Review of Unsampld Resident A's clinical record revealed the facility admitted the resident on 10/27/15 for rehabilitation with diagnoses to include Urinary Tract Infection (UTI) and Diabetes. Review of the BIMS conducted on 11/03/15 revealed a score of fifteen (15) out of fifteen (15) indicating no cognitive impairment.

Review of the facility's "Follow up with Investigations from Abuse" document, dated 11/02/15, completed by the DON, revealed Unsampld Resident A revealed SRNA #1 "stood

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REVISED: 01-29-2011  
FORM APPROVED  
CMS NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X11 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185487	X0 MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	X4 DATE SURVEY COMPLETED  C 11/13/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 VERSAILLES ROAD LEXINGTON, KY 40504
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X2 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 COMPLETION DATE
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by his/her bedside fondling himself on the outside of his scrubs" Unsamped Resident A stated he/she was very uncomfortable and felt very vulnerable being left with him alone. Per the document, Unsamped Resident A thought SRNA #1 might do something to him/her sexually

4. Review of Unsamped Resident B's clinical record revealed the facility admitted the resident on 10/25/15 with diagnoses of Left Femoral Popliteal Bypass (a procedure used to treat femoral artery disease performed to bypass the blocked portion of the main artery in the leg using a piece of another blood vessel). Review of the BIMS conducted on 10/30/15 revealed a score of fifteen (15) out of fifteen (15) indicating the resident had no cognitive impairment.

Continued review of the "Follow up with Investigations from Abuse" document, dated 11/02/15, revealed SRNA #1 made Unsamped B feel very uncomfortable and "creeped out"

Additional review of the "Follow up with Investigations from Abuse" document, dated 11/02/15, revealed a subsequent interview with Unsamped Resident C. Per the document Unsamped Resident C revealed SRNA #1 was "a creep who was nuts". The document stated Unsamped Resident C was asleep and awoke to SRNA #1 stroking his/her left leg up and down which caused him/her to awaken and literally "scared me to death". Continued review, revealed Unsamped Resident C said the SRNA wanted him/her to go to the bathroom, so he/she told the SRNA "you never ever touch me like that without introducing yourself and telling me who you are". Further review of the document revealed Unsamped Resident C said she got into the

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FORM EPR02/03  
OMB NO. 0938-3397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	01 MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	03 DATE SURVEY COMPLETED  11/03/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504	

04 IS PREP TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.	05 PREP TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.	06 COMPLETION DATE
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bathroom by himself/herself and he watched standing in the bathroom beside him/her fondling himself. Per the document, this upset Unsampld Resident C so bad he/she literally was awake all night scared the SRNA would come back in the room.

Phone interview with the House Supervisor on 11/13/15 at 2:45 PM, revealed no investigation was started other than obtaining a statement from LPN #3 on 10/31/15. The House Supervisor stated SRNA #1 had worked at the facility on another unit previously and there had been no complaints related to the SRNA up to this time. Further interview revealed "I did not think he had hit them or anything. LPN #3 explained to me that he had been rough and scary". The House Supervisor revealed LPN #3 did not explain what "rough" meant. She stated she had been trained on Abuse and she was to document the incident in writing and report the incident to her supervisor who was the Chief Nursing Officer (CNO), and an investigation was done by the CNO or the Administrator. She further stated she had contacted the CNO on 10/31/15 early in the morning. The House Supervisor stated "if someone complained they were hurt, I would examine them". She revealed she did not think about the need to assess the residents who complained about SRNA #1 and did not think about the need to interview additional residents because she did not think anyone was hurt.

Interview with the Director of Nursing (DON), on 11/12/15 at 10:35 AM, revealed she was notified of the incident when she arrived at work on 11/02/15 and she immediately interviewed all of the residents on D Hall where SNRA #1 had worked regarding the concerns related to the care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	FACILITY PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  156467	10. MULTIPLE CONSTRUCTION # BUILDING _____  # WING _____	ALL DATE SURVEY COMPLETED  11/13/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2650 VERSAILLES ROAD LEXINGTON, KY 40504		
NID 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.	AB COMPLETION DATE

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provided by the SRNA #1

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Further interview with the DON, on 11/13/15 at 3:20 PM revealed the other residents on the floor should have been interviewed prior to 11/02/15. She stated she was not sure if skin assessments were done after the allegations and agreed they should have been completed and documented. The DON revealed, on 11/03/15 at 12:00 PM she called the employment agency and reported the final results of her investigation.

Interview with the CNO, on 11/13/15 at 11:00 AM, revealed she was in charge in the absence of the Administrator and Director of Therapy Operations. The CNO stated she received a phone call on the morning of 10/31/15 about 7:30 AM and she came to the facility to discuss the concerns with the House Supervisor and fulfill her reporting obligations to the Office of Inspector General and the employment agency in which SRNA #1 worked, and they addressed and reported the incident within twenty-four (24) hours. The CNO stated as far as she knew they had followed their Abuse Policy. However, there was no documented evidence of a thorough investigation completed as per policy.

Further record review revealed no documented evidence of Social Services involvement in monitoring the resident's emotional well-being concerning the incidents as per policy. Phone interview with the Case Manager of Social Work, on 11/13/15 at 4:00 PM, revealed there was two (2) Social Workers and neither of them were called in on this situation or informed what happened. She stated she did not find out about the incident until a few days later, when she asked the DON why she was questioning

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CMB NO. 0808-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	4. MULTIPLE CONSTRUCTION A. BUILDING  B. ALIAS	3. DATE SURVEY COMPLETED  11/03/2015
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS CITY STATE ZIP CODE

CARDINAL HILL REHABILITATION HOSPITAL

2060 VERSAILLES ROAD  
LEXINGTON, KY 40504

1. LSC PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES  
EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION

2. PREFIX TAG

PROVIDER'S PLAN OF CORRECTION  
EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY

3. NUMBER DATE

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residents. She stated she was not asked to get  
involved and did not get involved in any way.

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