STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265425	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the guardian/responsible party for one sampled resident (Resident #4) of 14 sampled residents. On 3/24/26 Resident #4 had a fall was transported and admitted to the hospital. The legal guardian was not notified until 3/25/26. The facility census was 72 residents.Review of the facility's Incidents and Accidents Policy dated 5/18/24 showed:-The resident's family or representative should be notified of the incident/accident and any orders obtained or if the resident was to be transported to the hospital. -Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, orders obtained and all follow-up interventions. 1. Review of Resident #4's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Schizoaffective disorder, bipolar type (a mental health condition marked by a mix of symptoms including schizophrenia and mood disorder symptoms).-Undifferentiated schizophrenia, (a mental health condition that affects how people think, feel and behave, and may result in a mix of seeing or hearing things not observed by others, disorganized thinking and behavior). Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 4/1/26, showed he/she was cognitively intact. Review of the resident's Care Plan Report revised 4/30/24 showed:-He/She had impaired thought processes related to decision making due to diagnoses of schizophrenia and bipolar disorder.-He/She had a legal guardian.-Interventions included communication with the resident/family/caregivers regarding the resident's capabilities and needs. Review of the resident's Un-witnessed Fall Report showed:-He/She had a fall in the facility dining room on 3/24/26 while standing and attempting to purchase soda.-Pre-disposing factors are walking without assist, unsteady gait, joint pain and drowsiness.-He/She reported feeling dizzy before the fall and fell into his/her wheelchair.-His/Her jaw hit the wheelchair, and his/her chest hit the ground.-He/She was oriented to person, place, time and situation.-The nurse assessed the resident after the incident.-Vital signs and condition were monitored; wounds were identified, and initial care was provided.-A possible head injury was suspected.-The acting Director of Nursing (DON) and Nurse Practitioner were notified.-The resident was transferred to the hospital for further evaluation and treatment.-There was no documentation notifying the legal guardian.During an interview on 3/26/26 at 11:29 A.M. the resident's legal guardian said:-The facility had not notified him/her timely the resident was in the hospital. -The hospital was not notified that the resident had a legal guardian on admission. During an interview on 4/3/26 at 1:00 P.M., the resident said:-He/She was aware he/she went to the hospital due to a fall.-He/She did not know what the procedure was for notifying his/her legal guardian about things. During an interview on 4/3/26 at 1:30 P.M., Licensed Practical Nurse (LPN) A said:-He/She was the nurse when the resident's fall occurred.-He/She did not call the resident's legal guardian when it happened. -He/She called the legal guardian the following day. -There was so much going on, he/she forgot to make the call. -He/She did not document that he/she called the legal guardian the following day. -When he/she called the legal guardian he/she was upset that he/she did not call at the time of the fall. -The facility (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy was that the legal guardian and the family were to be notified as soon as possible. -He/She forgot to do it. It was his/her fault. It was a mistake. During an interview on 4/6/26 at 2:26 P.M., the Director of Nursing (DON) said:-Nurses were educated to call the legal guardians regarding incidents.-The legal guardian should be notified as soon as possible and given details about what was going on with the residents.-The expectation was that the resident should be assessed, and then notification to the DON, administrator, physician and legal guardian. During an interview on 4/6/26 at 2:30 P.M., the Administrator said:-The expectation was that the legal guardian should be notified, along with the DON, the Administrator, and the physician if an event with a resident occurs.-The legal guardian should really be notified in the first thirty minutes after an incident.-If that was not possible, notification should occur as soon as possible and definitely before the staff left the building. 2965179

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent abuse for one sampled resident (Resident #8) out of fourteen sampled residents. On 4/2/26, Resident #7 attacked Resident #8 while Resident #8 was in bed, resulting in superficial scratches on Resident #8's face, arm, abdomen and back. The facility census was 72 residents.Review of the facility's Abuse and Neglect Policy dated 6/12/24 showed:-Abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which could include staff-to-resident abuse and certain resident-to-resident altercations. Purposely included beating, striking, wounding or injuring any resident or in any manner mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse also included, but was not limited to, hitting, slapping, punching, biting and kicking. 1.Review of Resident #7's Level One Nursing Facility Pre-admission Screening for Mental Illness dated 5/6/20 showed he/she had the following diagnosis: -Vascular dementia, (a disorder that damages brain tissue because of lack of blood flow). -Cerebral infarction (a medical emergency caused by a blockage in a blood vessel feeding the brain)-Hemiplegia (paralysis on one side of the body). -Hemiparesis (weakness on one side of the body). Review of Resident #7's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Cerebral infarction, (a stroke which occurs as a result of disrupted blood flow to the brain).-Unspecified dementia without behavioral disturbance, (a condition in which a person loses he ability to think, remember, learn, make decisions and solve problems).-Unspecified mood disorder, (a mental health disorder characterized by a disturbance in mood which is abnormally depressed or elated).-Schizoaffective disorder, (a mental health condition that includes features of both schizophrenia, (a serious mental illness that affects how a person thinks, feels, and behaves) and a mood disorder. Review of Resident #7's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 2/3/26, showed the resident was cognitively impaired. Review of Resident #8's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Schizoaffective disorder. -Mild neurocognitive disorder (the in-between stage between typical thinking skills and dementia).-Anxiety disorder (a mental disorder which involves more than occasional worry or fear).-Sequelae of cerebral infarction (effects of a stroke)-Cognitive communication deficit (a problem with communication due to disruption in cognitive processes). Review of Resident #8's Quarterly MDS dated [DATE], showed he/she was cognitively intact. Review of the Incident Report for Physical Aggression Involving Head for Resident #8 dated 4/3/26 showed: -Licensed Practical Nurse (LPN) B was alerted to the residents' room by staff members due to a physical altercation involving Resident #7.-Resident #8 was laying in his/her bed yelling, Call the police!.-Resident #8 stated he/she was sleeping, and Resident #7 woke him/her up and asked him/her if he/she would close the window for him/her because he/she was cold.-Then Resident #7 attacked him/her.-The residents were immediately separated in two separate locations in the facility.-Resident #8 was oriented to person, place, time and situation. -Resident #8's injuries at the time were located on the chest, abdomen, face, right wrist, right shoulder, right posterior forearm, right upper arm and right eye. Review of Resident #7's Progress Note dated 4/3/26 at 11:30 A.M. showed:-He/She was identified as the aggressor in prior resident to res ident altercation and was assessed by the Director of Nursing (DON) B.-He/She was alert and oriented to person, place and time.-He/She was calm, cooperative and appropriate during the interaction.-No visible injuries were noted, and vital signs were within normal limits.-He/She denied pain or discomfort.-He/She acknowledged involvement in the incident and offered an apology. Review of Resident #8's Progress Note Skin Check dated 4/3/26 at 3:13 A.M. showed:-He/She had multiple scratches to the face, shoulder, chest, abdomen, upper right arm and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	lower right arm. Review of Resident #8's Hospital Specialty Documentation dated 4/3/26 at 10:12 A.M. showed:-The resident was presenting status post assault.-Per Emergency Medical Staff (EMS) patient was assaulted while sleeping in bed at his/her living facility last evening (4/2/26).-Patient seemed confused on presentation and was a poor historian.-Staff were unable to gather further details of what transpired.-Patient complained of pain upon evaluation, however was unable to clearly vocalize where he/she felt severe pain.-Patient had abrasions to anterior right chest.-Patient reported being assaulted by another patient using fists. He/She endorsed when he/she believed he/she was hit he/she fell to the floor and hit his/her head.-Patient had eye laceration, right eye pain.-He/She had an approximately 2 centimeter (cm) very superficial laceration noted to the interior aspect of the right eyebrow. During an interview on 4/3/26 at 11:33 A.M., Resident #7 said:-He/She did not initially remember getting into a fight. -He/She was cold and wanted the window closed. -His/Her roommate, Resident #8, wanted the window open, because he/she was hot. -He/She was freezing. -He/She told Resident #8 he/she was going to beat his ass because he/she was fed up. If Resident #8 was hot, he/she should go outside.- I whooped his/her ass. -He/She was not trying to harm Resident #8 - just get his/her point across. -It wasn't a good idea to hit people. -He/She had not hit anyone else at this facility. -The police came and talked to him/her and asked him/her what was going on and he/she told them the same thing. -The police said not to have them come back out and he/she said fine. During an interview on 4/3/26 at 11:57 A.M., Resident #8 said:-This happened last night. -He/She didn't know what Resident #7's problem was. -Resident #7 was cold. -He/She had been in his/her bed asleep. -Resident #7 wanted the window closed. -Resident #7 said Hey, hey, hey!. -Resident #7 said he/she was going to beat his/her ass.-Resident #7 did not say why he/she was hitting him/her. -The nurses came in time to save his/her life. -He/She was lucky to be alive. -It was Resident #7 fingernails that cut him/her. -This is the first time he/she had a fight with Resident #7. -He/She was afraid of Resident #7 now. -He/She had never had a fight with any other residents.-He/She did not feel good about it. He/She felt bad. -He/She just wanted to go home. Review of Resident #8's Progress Note Skin Check dated 4/3/26 at 1:31 P.M. showed:-He/She had new skin issue which was an abrasion on his/her right outer forearm which was new.-He/She had a new skin issue located on his/her right eyelid which was an abrasion.-He/She had a new skin issue located on his/her right eyebrow which was an abrasion.-He/She had six scratches to his/her right arm. During an interview on 4/3/26 at 3:49 P.M., LPN B said:-Resident #7 said he/she was cold because the window was open. -Resident #8 was sleeping in his/her bed.-Resident #7 woke Resident #8 up and asked him/her if he/she could close the window because it was cold.-Resident #8 said he/she went to get out of the bed and as soon as he/she got up, Resident #7 attacked him/her, but did not say why. -When Resident #8 asked Resident #7 why he/she did it, Resident #7 just said, 'because' and that was all he/she would say. -Nobody witnessed this; the residents were in their room. -The two aides that were on the floor heard the commotion in the room and went in and separated the two residents. -These two residents had not argued before, to his/her knowledge. -This incident happened on the night shift. -He/She did the skin assessment on Resident #8. He/She had a scratch on the corner of his/her right eye and scratches on his/her abdomen, shoulder, chest and his right arm which looked like fingernail scratches.-Resident #8 insisted on going to the hospital. He/She thought Resident #8 wanted to get out of the facility because he/she kept saying, I just want to go home. -Typically, residents would not go out to the hospital for superficial scratches. During an interview on 4/16/26 at 1:28 P.M., CNAA said:-He/She was working the night of the altercation between Resident #7 and Resident #8.-The last time he/she saw the residents was during his/her rounds, but he/she could not recall what time that was.-He/She was not aware that Resident #7 did not like the room to be cold, although sometimes the resident did ask him/her for an extra blanket.-It should have been communicated to the staff that Resident #7 did not like the room to be cold.-There was a loud shout and that was when he/she went into the room.-He/she separated the residents. -It would be abuse if a resident hit another resident. Review of Resident #8's Psychosocial Post-Incident Impact (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Questionnaire dated 4/3/26 at 6:55 P.M. showed: -He/She was the victim in the incident.-He/She did not want to remain in the same room with Resident #7.-He/She was scared of Resident #7.-He/She was good now that his/her room had been changed.-He/She yelled for help. He/She did not do anything. -The staff helped him/her and the police came.-He/She felt safe but wanted Resident #7 told to leave him/her alone.-He/She was scared. He/She did not want any problems.-He/She had scratches on his/her arm and face. During an interview on 4/6/26 at 12:33 P.M., the DON said:-Resident #7 stayed cold; his/her brother brought him/her different clothes and blankets.-It could be 100 degrees and Resident #7 would say it was cold.-Resident #7 wanted to close the window on his/her own and did not call for help.-The incident was abuse. During an interview on 4/6/26 at 2:10 P.M., the Administrator said:-He/She did not think anything could have been done differently.-They could not have predicted Resident #7 would attack his/her roommate.-Resident #7 asked his/her roommate to close the window.-Residents had the right to sleep and not be hit.-It was abuse when a resident started beating another resident up. During an interview on 4/6/26 at 2:20 P.M., Physician A said:-Resident #8 was his/her patient.-Abuse was a case-by-case issue.-Just because a resident hit another resident, it may not be abuse.-He/She expected any of his/her patients not to be hit. 2972766, 2972909

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate, necessary behavioral health services for one sampled resident (Resident #7) out of 14 sampled residents. On 04/2/26, facility staff failed to implement the resident's care plan for behavioral interventions related to environment. The facility census was 72 residents.Review of the facility's Behavioral Health Services Policy, revised 10/31/24, showed:-The purpose of the policy was to ensure all residents received necessary behavioral health services to assist them in reaching and maintain their highest level of mental and psychosocial functioning.-The facility staff were to ensure the residents were receiving necessary behavioral health care which were person-centered and reflect the resident's goals for care while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.-Behavioral health care and services were to be provided in an environment that was conducive to mental and psychosocial well-being. -The facility staff were to monitor the resident closely for expressions or indications of distress.-If the resident showed signs of distress, the staff were to evaluate if those changes in behavior were unavoidable.-The facility staff were to develop person-centered care for any concerns identified with the resident.-The facility staff were to have interventions that were person-centered, evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice. 1.Review of Resident #7's Level One Nursing Facility Pre-admission Screening for Mental Illness dated 5/6/20 showed:-He/She had vascular dementia, (a disorder that damages brain tissue because of lack of blood flow), cerebral infarction, hemiplegia, (paralysis on one side of the body), hemiparesis, (weakness on one side of the body).-Plan of care for staff was to provide a safe environment for the resident and to be supervised for safety. Review of Resident #7's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Cerebral infarction, (a stroke which occurs as a result of disrupted blood flow to the brain).-Unspecified dementia without behavioral disturbance, (a condition in which a person loses he ability to think, remember, learn, make decisions and solve problems).-Unspecified mood disorder, (a mental health disorder characterized by a disturbance in mood which is abnormally depressed or elated).-Schizoaffective disorder, (a mental health condition that includes features of both schizophrenia, (a serious mental illness that affects how a person thinks, feels, and behaves) and a mood disorder.Review of Resident #7's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 2/3/26, showed the resident assessed as cognitively impaired. Review of Resident #7's Care Plan Report updated 2/12/26 showed:-The resident had the potential to be physically aggressive toward peers, related to poor impulse control.-Interventions included: two hour rounding with focus on ensuring he/she was dry, warm and repositioned; verifying he/she had sufficient blankets and appropriate nighttime clothing; monitoring for restlessness and agitation and redirection using calm verbal cues. Review of Resident #8's Quarterly MDS dated [DATE], showed he/she assessed as cognitively intact. Review of the Incident Report for Physical Aggression Involving Head for Resident #8 dated 4/3/26 showed: -Licensed Practical Nurse (LPN) B was alerted to the residents' room by staff members due to a physical altercation involving Resident #7.-Resident #8 was laying in his/her bed yelling, Call the police!.-Resident #8 stated he/she was sleeping, and Resident #7 woke him/her up and asked him/her if he/she would close the window for him/her because he/she was cold.-Resident #7 attacked him/her.-The residents were immediately separated into two separate locations in the facility.-Resident #8 was oriented to person, place, time and situation. -Resident #8's injuries at the time were located on the chest, abdomen, face, right wrist, right shoulder, right posterior forearm, right upper arm and right eye. Review of the undated facility Risk Management Incident Report showed:-The incident occurred in the late evening hours. - Emergency Medical (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services (EMS) was activated at 11:46 P.M. and arrived at 11:57 P.M.-The incident was a resident-to-resident altercation.-Staff were alerted to a physical altercation occurring between roommates in their shared room. Upon arrival, Resident #8 was observed lying in bed, visibly upset, yelling, Call the police,-Resident #8 reported he/she had been asleep when his/her roommate, Resident #7, woke him/her and asked him/her to close the window because he/she was cold.-Resident #8 stated he/she attempted to get out of bed to assist when Resident #7 suddenly became physically aggressive and attacked him/her without further provocation.-Upon assessment, Resident #8 was noted to have multiple visible scratches to the face, chest, shoulder, abdomen, right upper arm and right lower arm. No additional injuries were observed at that time.-Resident #8 reported pain and requested a hospital evaluation.-Resident #8 requested police involvement and transport to the hospital.-Resident #7 stated he/she was cold, woke Resident #8 to close the window, and when Resident #8 got up, he/she (Resident #7) beat his/her (Resident #8) ass.-Root cause analysis showed the primary cause of the incident was placing a known aggressive resident (Resident #7) in a shared room.-Contributing factors were sleep disruption (trigger); environmental discomfort (temperature, window); poor impulse control (Resident #7); neurocognitive and psychiatric diagnoses (both residents); lack of protective intervention despite behavioral history.-System failure included: failure to evaluate roommate compatibility; lack of preventive intervention; inadequate behavioral risk management.-Gaps and weaknesses were: failure to remove aggressive resident from a shared room; documented roommate compatibility assessment; environmental triggers not managed; failure to implement higher level supervision prior to the incident; no escalation to psychiatric/PASSR reviews sooner.-The conclusion was the incident was a confirmed resident to resident assault resulting in injury and hospital transfer.-The root cause was failure to manage a resident with known aggressive behaviors within a shared room setting.-Systemic failures in behavioral management, supervision and roommate placement contributed to the event.-The facility identified the root cause as failure to appropriately manage a known aggressive resident within a shared living environment. During an interview on 4/3/26 at 11:33 A.M., Resident #7 said:-He/She did not initially remember getting into a fight. -He/She was cold and wanted the window closed. -His/Her roommate, Resident #8, wanted the window open, because he/she was hot. -He/She was freezing. -He/She told Resident #8 he/she was going to beat his ass because he/she was fed up. -If Resident #8 was hot, he/she should go outside.-He/She said, I whooped his/her ass. -He/She was not trying to harm Resident #8 it was just get his/her point across. -It wasn't a good idea to hit people. -He/She had not hit anyone else at this facility. -The police came and talked to him/her and asked him/her what was going on and he/she told them the same thing. -The police said not to have them come back out and he/she said fine. During an interview on 4/6/26 at 12:55 P.M., the Director of Nursing (DON) said:-There was a lack of preventive intervention with the two residents.-Resident #7 was triggered by environmental issues, like being cold.- Usually when a resident had begun to show signs of being aggressive, the resident was moved .-Resident #7 needed staff assistance with activities of daily living (ADLs) and Resident #8 did not, which is why they were roommates. The failure to Resident # 7 to a different or private room resulted from Resident #7's blindness and relationship to the room. -Neither resident used his/her call light for assistance, and it was dark. Luckily, the nurse was rounding and intervened right away.-If this had happened during the day, Resident #8 probably would have used his/her call light. In the dark, both residents were startled.-The residents could have been reminded to use their call lights if they had issues.-Certified Nurses Aide (CNA) A could have used due diligence when they put Resident #7 to bed and checked the window, it might have stopped the incident from happening. Since the staff were aware that Resident #7 had an issue with being cold, the CNAs could have been proactive on room comfort and closed the window.-Preventive intervention could be to make sure of the comfort of both residents while in the room. During an interview on 4/6/26 at 2:00 P.M., the Interim DON said:-One the resident to resident incident, (Resident #7 and Resident #8), the root cause was behavioral.-Resident #7's medical history indicated he/she had behaviors.-He/She thought (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's behaviors were being managed, but the incident happened because it was nighttime.-Resident #7's eyesight could have been an issue.-The open window was close to Resident #8.-It would be normal for a resident to be startled if awakened in the dark.-Resident #7 should have used his/her call light instead of waking Resident #8 up.-Possibly Resident #7's cognitive issues might have caused him/her to react.-Residents were reminded to use their call lights.-Giving Resident #7 a private room could have prevented the incident knowing Resident #7 could be aggressive. During an interview on 4/6/26 at 2:10 P.M., the Administrator said:-Related to behavior management, it may have been an environmental factor.-Resident #8 liked the cold room and Resident #7 liked it warm, so they were not compatible.-The root cause of the incident was environmental factors.-The aides should have noted if residents were comfortable or not. During an interview on 4/16/26 at 1:28 P.M., CNA A said:-He/She was working the night of the altercation between Resident #7 and Resident #8.-The last time he/she saw the residents was during his/her rounds, but he/she could not recall what time that was.-He/She was not aware that Resident #7 did not like the room to be cold, although sometimes the resident did ask him/her for an extra blanket.-It should have been communicated to the staff that Resident #7 did not like the room to be cold.-Usually when he/she saw the residents, they were in bed.-There was a loud shout and that was when he/she went into the room.-When the staff did rounds, they would check and change the residents who needed it, and he/she would check every resident to make sure they were breathing.-It would probably be appropriate to check Resident #7's room to make sure it was not cold.-He/She did not know of a place where the residents' triggers could be checked.-He/She did receive computer education about abuse and resident rights; however, they did not enforce continued computer training and were just given a packet of papers to sign stating they understood abuse and resident rights. 2972766, 2972909