Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001275	A. BUILDING: ______ B. WING ______	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

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S 000	Initial Comments Facility Reported Incident of October 9, 2021 IL139890	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b) 300.1210 d)6) 300.2040 e) 300.3240 a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.2040 Diet Orders

e) A therapeutic diet means a diet ordered by the physician or dietitian as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).

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S9999	Continued From page 2	S9999		

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on interview and record review,the facility failed to provide supervision during meal service to a visually impaired resident with dementia; failed to serve a resident food consistent with a mechanical soft diet; and failed to assess for a patent airway and attempt to clear an obstructed airway in an unconscious resident for 1 of 1 resident (R2) reviewed for supervision during meals, therapeutic/mechanically altered diets, and emergency basic life support in the sample of five. This failure resulted in R2 aspirating a whole brussel sprout on 10/09/21, with R2's airway becoming occluded, staff providing ineffective rescue breathing, and R2 subsequently expiring.

R2's Continuity of Care Document listed an admission date of 12/28/18, and diagnoses of "Alzheimer's Disease, unspecified, effective date 2/24/20, status: Active," and "Dysphagia, oropharyngeal phase, effective date 10/06/20, status: Active."

R2's 12/02/20 POLST (IDPH/Illinois Department of Public Health Uniform Practitioner Order for Life Sustaining Treatment) form documented, "Full treatment-attempt CPR (Cardiopulmonary Resuscitation)."

A Speech Therapy Plan of Care, authored by V9, former Speech Language Pathologist,

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S9999	Continued From page 3 documented, "Treatment Diagnosis: Dysphagia, Oropharyngeal phase. Start of care: 10/06/20. End of Care: 10/30/20. Therapy (is necessary) for increased safety/efficiency of swallow(ing) to tolerate safe and adequate tolerance of (the) least restrictive diet. Without therapy, the patient is at risk for choking/weight loss/malnutrition. The patient does have upper dentures in place." A 10/30/20 Speech Therapy Progress and Discharge Summary, authored by V9 documented, "The patients gains during this course of skilled speech therapy have resulted in diet advancement from puree to mechanical soft. Mild dysphagia given the mechanical soft diet. Staff education given regarding continuation of all food in bowls, and assisting patient as needed with transition from bowl to bowl." R2's 7/21/21 quarterly Minimum Data Set (MDS) documented R2 required limited assistance from at least one staff member for eating, and R2 was severely visually impaired. The same MDS documented a Brief Interview for Mental Status score of zero, indicating R2 had severe deficits in cognition, and required a mechanically altered diet. R2's Continuity of Care Document listed diagnoses of Alzheimer's Disease, Moderate Protein Calorie Malnutrition, and Iron Deficiency Anemia. R2's Physicians Order Sheet documented an order for a mechanical soft diet with thin liquids, with special instructions to serve all food in bowls. R2's Care Plan, with a review date of 08/03/21, documented a problem area, "Resident requires a mechanically altered diet", with the corresponding approaches, "Provide assistance for meal. Responsible staff: CNA, nursing. (Obtain)Speech Therapy consult. Follow recommendations. Assure dentures, partial plates, etc. are in place before meals. Assure a	S9999		

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S9999	Continued From page 4 proper fit." A 10/19/20 Speech Therapy Diet Order signed by V9. Former Speech Therapist, documented, "Mechanical soft, thin liquids." A Serious Injury Incident Report submitted via fax to the Illinois Department of Public Health, dated 10/18/21, documented, "(R2) unexpectedly passed away on the evening of 10/09/21 ...At approximately 5:45pm, (R2's) meal tray was delivered to him. Set up of the meal was provided by staff. He was appropriately seated in his recliner. At approximately 6:10pm, a CNA went to his room. He had removed his food soiled gown, which was his common practice. The CNA and (R2) had a brief conversation. The CNA picked up his tray and all food items. She took the tray and all food items from room and retrieved a clean gown and brief for him. Approximately 3 to 5 minutes later, she returned to his room and found him with his hand folded and head dropped in his chair. She immediately called for nurse assistance. (The) nurse checked for pulse and breaths. Finding no pulse or breaths, CPR (Cardiopulmonary Resuscitation) was initiated and continued until EMS (Emergency Management Services) arrived on the scene to take over. EMS hooked him up to a (trade name mechanical chest compression device) and attempted to intubate. Upon intubation, a partially chewed brussel sprout was discovered. EMS pronounced him dead at 6:51pm. (The) Coroner transported his body to the morgue pending an autopsy. An autopsy was performed on 10/14/21. The preliminary results indicated that his death was accidental due to choking on food due to advanced Alzheimer's Disease with no signs of negligence. (R2) had a diagnosis of Alzheimer's Disease, PVD (Peripheral Vascular Disease), CKD III (Chronic Kidney Disease Stage 3), other seizures, and Major Depressive Disorder. His	S9999		

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S9999	Continued From page 5 BIMS (Brief Interview for Mental Status) indicated a staff assessment was necessary. He had long and short term memory problems and had moderately impaired daily decision making ability. He was on a mechanical soft diet. Per autopsy, all food found in his system was appropriately chopped per diet order." On 11/04/21 at 10:30am, V3 (Emergency Medical Technician/EMT) stated on the evening of 10/09/21, the ambulance service for which V3 is employed, received a call to respond to the facility for a possible cardiac arrest. V3 stated when the team arrived on scene at around 6:30pm, two facility staff were performing compressions and rescue breathing for R2. V3 stated V3 relieved the staff member providing rescue breathing, and checked the patency of R2's airway. V3 stated upon visual inspection, V3 saw a large green mass lodged in the airway. V3 attempted to suction the object out, but was unsuccessful. V3 then used forceps to pull out the object, which V3 stated was a solid, unchewed, whole brussel sprout. V3 stated one of the facility staff relayed R2 had brussel sprouts for dinner, and R2 was on a mechanical soft diet. V3 stated EMS staff continued with rescue breathing and compressions, but R2 failed to respond, and the team's lead paramedic contacted their physician, who pronounced R2's time of death at 6:51pm. V3 stated the brussels sprout was sent to the coroner's office along with body. On 11/04/21 at 11:05am, V4 (CNA) stated on the evening of 10/09/21, V4 and V5 (CNA) were working together on the Center/East Hall/Suites units during dinner. V4 stated V5 was passing trays, and V4 was feeding residents. V4 stated they began getting trays to resident rooms at about 5:45pm. V4 stated V4 did not bring in R2's	S9999		

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S9999	Continued From page 6 tray or set up his meal, V4 assumes V5 did. V4 stated R2 was on a mechanical soft diet, and had food served to R2 in separate bowls due to visual deficits. V4 stated R2 was very confused, but at times could engage in limited conversation with staff. V4 stated R2 used a combination of fingers and utensils to eat. V4 stated staff would give R2 a bowl and utensil, then come back and check on R2 and give R2 another bowl, and continue until R2 was finished. V4 stated this was the routine staff used with R2 during meals. V4 stated V4 was done feeding residents and looked in on R2 at about 6:10pm. V4 stated R2 had food everywhere, and soiled clothing which was usual for R2. V4 stated R2 looked tired, and V4 asked R2 if R2 wanted to go to bed, and R2 said yes, "I'm tired." V4 stated V4 picked up R2's tray and bowls, and noticed the brussels sprouts were whole. V4 stated other residents on mechanical soft diet had also been served whole brussels sprouts that evening, and residents on regular consistency diets had complained they were chewy, so V4 had taken them off the trays of the residents on mechanical soft diets. V4 stated V4 took the tray and bowls out of the room, and left to go get R2 a clean gown and brief. V4 stated V4 was gone only a couple of minutes, and when V4 returned, R2 was sitting with R2's head down with mucus coming from R2's mouth and nose; R2 was cold, and unresponsive. V4 stated V4 ran and alerted V6 and V7, (both Licensed Practical Nurses/LPN's). V4 stated V5 and V5 got R2 onto the floor and began CPR, with V4 doing compressions and R5 performing rescue breathing, until the EMTs arrived in five or ten minutes. V4 stated V4 then went out into the hall. V4 stated V4 didn't see the EMTs intubate R2, but stated one of the EMTs brought V4 a whole, solid brussel sprout and said they took it out of R2's airway, and they said for V4 to save it. V4 stated	S9999		

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S9999	Continued From page 7 R2 did have a roommate, R5, but R5 always ate in the hallway for supervision and support, and R2 was unable to ambulate without assistance and could not have accessed R5's tray. V4 stated in retrospect, V4 now wonders if R2 had a brussel sprout laying in his chair and put it in R2's mouth when V4 left to get his clean linens. On 11/04/21 at 11:05am, V4 (CNA) stated V4 found R2 sitting in R2's recliner, unresponsive, without a pulse or respirations. V4 stated V4 ran to get V6 (Licensed Practical Nurse/LPN), who stated R2 was a full code. V4 stated V4 and V5 (CNA) lowered R2 to the ground, V5 put a pillow under R2's head, and V4 began performing chest compressions, while V5 performed rescue breathing. V4 stated V4 does not recall V5 doing a visual inspection or finger sweep of the mouth prior to providing rescue breaths, and V4 stated she also did not check for airway patency. V4 stated staff did not discuss a potential choking incident, because staff assumed R2 had a heart attack or a stroke. V4 stated neither V4 nor V5 attempted the Heimlich maneuver. V4 stated V4 and V5 changed positions "a few times" until EMTs responded and took over. V4 stated V4 recalled V4 did not think air was going into R2's lungs, but neither V4 nor V5 attempted to check the patency of R2's airway. On 11/04/21 at 11:45am, V6 (LPN) stated on 10/09/21 at about 6:20pm, V6 was giving report to V7 (LPN) at the nurse's station when they were alerted by V4 that R2 was unresponsive. V6 corroborated V4's account of the events as stated above. V6 stated V6 did not see EMTs intubate R2, but V4 brought V6 the whole, solid brussel sprout and said "We need to keep this, they found it in (R2's) airway." V6 stated the sprout was then sent with the body to the coroner's	S9999		

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S9999	Continued From page 8	S9999		

office. V6 stated V6 does not know who set up R2's tray that evening. V6 stated R2 was visually impaired and had dementia. V6 stated R2 was on a mechanical soft diet, and R2 always took R2's pills crushed mixed with pudding as R2 was at risk for aspiration. V6 stated V6 does not know who set up R2's tray that evening. V6 stated R2's food was served in bowls one at a time, R2 would put it up to R2's mouth and use fingers or utensils depending on his mood. V6 stated staff would leave the room and come back to check on R2, and switch out R2's bowls.

On 11/04/21 at 11:45am, V6 (LPN) stated while V4 and V5 performed CPR, V6 was calling the ambulance and notifying R2's physician and family. V6 stated V6 was not in R2's room for the entirety of the event, and therefore cannot be sure if the patency of R2's airway was checked. V6 stated V6 recalls watching V4 and V5 perform CPR, and noting R2's abdomen, not chest, was rising during rescue breaths. V6 stated V6 did not attempt to intervene by checking the patency of the airway, nor performing the Heimlich maneuver. V6 stated staff assumed R2 had a stroke or cardiac event.

On 11/05/21 at 1:00pm, V5 stated V5 was working with V4 the evening of 10/09/21. V5 stated V5 was passing trays and took R2 his tray at about 5:45pm. V5 stated V5 noticed R2's tray contained ground meat and potatoes, but R2 had been given whole brussel sprouts. V5 stated other residents had already complained to V5 that the sprouts were too tough and chewy. V5 stated at that time, it did not occur to V5 that R2 might choke on the sprouts. V5 stated V5 placed R2's tray on R2's over bed table within R2's reach, and handed R2 a bowl of chopped meat. V5 stated R2 could switch out the bowls by himself when

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S9999	Continued From page 9	S9999		

R2 was finished, and V5 assumed R2 got the bowl of sprouts when R2 was done with the meat. V5 stated V5 continued passing trays, and did not enter the room again until V5 and other staff responded when R2 was found unresponsive. V5 stated during CPR, V5 was ventilating R2 with a bag valve mask, and was not sure if air was going into R2's lungs or not. V5 stated EMTs arrived on the scene and took over rescue efforts.

On 11/09/21 at 12:30pm, V5 (CNA) stated when V5 and V4 (CNA) found R2 unresponsive with no pulse and respirations, they moved R2 from the recliner onto the floor. V5 stated V5 placed a pillow under R2's head. V5 stated V5 then placed a valve mask apparatus, without the bag, over R2s mouth and nose and began providing rescue breaths. V5 stated V5 did not check the patency of the airway prior to providing rescue breaths, either by performing a visual inspection, or finger sweep for occlusion. V5 stated V5 was not sure if air was going into R2's lungs, and at some point, V4 also stated V4 did not think R2's lungs were inflating. V5 stated V5 did not attempt to reposition R2's head, do a finger sweep, or do a visual inspection. V5 stated staff did not discuss the possibility of choking, so the Heimlich maneuver was not attempted. V5 stated V5 and V4 switched positions two or three more times until EMTs arrived on the scene and took over.

On 11/05/21 at 10:50am, V10, CNA, stated there had been occasions just prior to R2's death when R2 ate his meals in the hall "so he could be monitored", but V10 stated V10 is not sure why, or under whose direction it was. V10 stated there was a list posted at the nurse's station of residents who were to eat in the hallway.

On 11/05/21 at 10:35am, V9 (SLP) stated R2 had

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S9999	Continued From page 10	S9999		

difficulty swallowing in part due to advanced dementia, hence the need for a mechanical soft diet. V9 stated it would not have been safe for R2 to consume brussel sprouts which were not cooked soft and had been chopped. V9 stated R2 would typically have eaten in the dining room, had Covid precautions not been in place at the time of his death, where R2 would have received more supervision. V9 stated with communal dining currently on hold, residents who require more supervision or cueing are typically placed in the hallway at mealtimes. V9 stated R2 should have had more direct supervision and placing R2 in the hall at mealtime would have provided this.

On 11/05/21 at 12:20 pm, V2, Director of Nursing, stated some residents who need more assistance or cues are placed in the hall at mealtimes. V2 stated R2 had been eating in the hall when R2 was agreeable to it, as R2 would sometimes refuse to leave R2's room. V2 stated V2 felt staff giving R2 a bowl of food and coming back to check on R2 in a few minutes was adequate supervision for R2. V2 stated V2 was unsure if staff had tried to get R2 to eat in the hallway on the evening R2 passed away.

On 11/05/21 at 1:20pm, V4 stated V4 and V5 did not attempt to get R2 to eat in the hall that evening, as R2 required staff assistance with ambulating, and they did not have time that night.

On 11/09/21 at 11:00am, V18, CNA, stated until 11/09/21, at the nurse's station was a handwritten list of residents, including R2, who were to eat in the hall for increased supervision. V18 stated V18 is not sure who authored the list, and V18 stated it is no longer there. V18 stated were it not for Covid precautions, R2 would have eaten in the dining room where R2 would have had increased

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S9999	Continued From page 11	S9999		

monitoring and supervision, but with communal dining currently on hold, V18 would put R2 in the hall, make sure R2's food was cut up, and hand R2 a bowl. V18 stated V18 made sure the other bowls were covered and out of R2's reach so R2 could not access them until V18 came back and gave R2 another bowl.

On 11/09/21 at 11:15am, V2, stated V2 did not know of the existence of the above referenced list nor who might have authored it.

On 11/03/21 at 12:05 pm, V8, Cook, stated V8 was working the evening of 10/09/21. V8 stated the supper menu included ham, au gratin potatoes, and brussel sprouts. V8 stated for mechanical soft diets, cooked food is pulsed in a commercial food processor with liquid until chopped. V8 stated R2 was on a mechanical soft diet. V8 stated V8 placed frozen brussel sprouts on the stove at 2:00pm, and they were cooked until 3:15pm. V8 stated the brussel sprouts were then soft, and V8 pulsed them in the food processor until chopped small. V8 stated the sprouts were processed with cooking liquid and butter. V8 stated they were then held on the steam table until service began at approximately 4:30pm. V8 stated each resident's diet card is placed on the tray, and the card is checked prior to the food being plated to ensure each resident receives the correct diet. V8 stated the kitchen received no negative feedback that evening about the sprouts. V8 stated residents on regular diets were served the whole sprouts, prepared the same way, but not chopped.

A 10/09/21 Dinner Diet Spreadsheet listed, "Brussel Sprouts: (mechanical soft): (serve) 4-ounce spoodle, (cooked) soft (and) chopped."

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RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

(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
S9999	Continued From page 12 On 11/05/21 at 1035 am, V9 stated R2 had difficulty swallowing in part due to advanced dementia, hence the need for a mechanical soft diet. V9 stated it would not have been safe for R2 to consume brussel sprouts which were not cooked soft and had been chopped. V9 stated R2 would typically have eaten in the dining room, had Covid precautions not been in place at the time of R1's death. V9 stated with communal dining currently on hold, residents who require more supervision or cueing are typically placed in the hallway at mealtimes. V9 stated R2 should have had more direct supervision, and placing R2 in the hall at mealtime would have provided this. On 11/10/21 at 8:30am, V25 (Doctor of Osteopathy/R2's Physician) stated R2 had swallowing issues due to Alzheimer's dementia. V25 stated R2 was full code status. V25 stated since R2 became unresponsive during a meal, choking should have been suspected, and staff should have checked the airway via visual check and finger sweep, followed by the Heimlich maneuver if a blockage was identified, and if the Heimlich maneuver proved ineffective, the next step would be trying to blow the object into lungs. On 11/10/21 at 8:45am, V26 (Medical Doctor/Medical Director) stated the facility had not notified V26 of the above referenced incident with R2. V26 stated V26 was aware R2 was the patient of V25. V26 stated, "It sounds like a lot of re-education needs to happen with staff regarding therapeutic diets, supervision (of residents during eating) and CPR." V26 stated V26 was going to call administrative staff and set up an immediate meeting. On 11/05/21 at 12:40pm, V11 (Coroner) stated V11 was present for R2's autopsy which was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 13 performed on 10/14/21 by V23 (Medical Doctor/Medical Examiner/Pathologist). V11 stated the Deputy Coroner was on the scene and obtained the vegetable matter which V3 (EMT) retrieved from R2's airway. V11 stated R2's stomach contents also contained pieces of the vegetable. V11 stated V23 determined R2's death was due to accidental asphyxiation. An Autopsy Preliminary Report, dated 10/14/21, authored by V23, documented, "Immediate cause of death-choking on a food bolus-brussels sprout-(measuring) 4.5 by 2 by 2 centimeters." A Death Certificate, dated 10/09/21, documented, "Cause of death: Choking on a food bolus." An Assistance with Meals Policy, with a revision date of 2019, documented, "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident ...Facility staff will serve resident trays and will help residents who require assistance with eating." An undated Resident Nutrition Services Policy documented, "Each resident shall receive the correct diet, with preferences accommodated as feasible, and shall receive prompt meal service and appropriate feeding assistance ...Nursing personnel will ensure that residents are served the correct food tray. Prior to serving the food tray, the Nurses Aid/Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident. If there is doubt, the nursing supervisor will check the written physician's order. If an incorrect meal has been delivered, nursing staff will report it to the Food Service Manager so that a new food tray can be issued."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14	S9999		

A Therapeutic Diets Policy with a revision date of December 2008 documented, "Mechanically altered diets modified for medical or nutritional needs, will be considered therapeutic diets."

A CPR Policy, dated June 2016, stated, " ...To perform CPR, after you have determined that the resident is unresponsive, is not breathing, and has no pulse, first lay the patient on their back on a hard surface. Tilt the residents head back slightly and lift the chin to open the airway and check for breathing. If the resident is not breathing, use a (trade name bag valve mask) with a mask attachment for unventilated residents with one staff holding the mask tightly and keeping the head in a chin tilt position and the second staff member squeezing the bag to instill air to ensure full ventilation of the lung field." Guidance at The American Red Cross www.redcross.org, states, "CPR Steps: .....Open the airway. With the person lying on his or her back, tilt the head back slightly to lift the chin ...Deliver rescue breaths. If the chest does not rise with the initial rescue breath, re tilt the head before delivering the second breath. If the chest doesn't rise with the second breath, the person may be choking. After each subsequent set of 30 chest compressions, and before attempting breaths, look for an object, and if seen, remove it."

(AA)