

VIRGINIA LAWYERS WEEKLY

Vol. 25, No. 35

January 31, 2011

www.valawyersweekly.com

Man died after ‘eloping’ from assisted living facility

Confidential Settlement

Plaintiff's decedent was admitted to defendant's adult assisted living facility on Oct. 22, 2008, at 11:45 a.m. for a five-day stay for respite care, with the following diagnosis: mild to moderate dementia and Alzheimer's, right below-knee amputation with prosthesis, left big toe amputation, diabetes, congestive heart failure, pacemaker implant, mental confusion, left eye vision impairment and blind in the right eye at the age of 75.

Decedent was ambulatory, aided by his right leg prosthesis and walker, and had a wheelchair available to facilitate his mobility. Due to his cognitive impairment, decedent was reliant on the management and staff to secure exits with functional alarms at all times to prevent decedent from leaving the facility unsupervised.

At approximately 4:15 p.m. on the day of decedent's arrival, a facility staff member saw him in the hallway, moving unsteadily with his walker towards a door opening to an unsecured outside walkway. He was redirected to his wheelchair and assisted into the dining room.

Within approximately five minutes of being brought to the dining room, the decedent attempted to leave the dining room in his wheelchair. A staff member redirected him to his table and remained with him until dinner was served. The staff member sat with him until he finished his dinner at approximately 5:45 p.m., and returned him to his room.

At approximately 6:30 to 6:40 that evening, a staff member saw the decedent in his room, sitting on the side of his bed talking with his roommate. The roommate told the staff member that earlier in day he overheard the decedent tell a family member that he was not staying at this facility and was going home.



ZYDRON



SIX



GILL

Management and staff knew or should have known that the decedent, as a new resident with moderate dementia, would take days to adapt to his new surrounding, and would be a risk to wander from the facility.

At approximately 6:45 to 6:50 p.m. on the day of his arrival, decedent was found outside and to the side of the facility's building, face-down in an unsecured 8-foot drainage ditch with his wheelchair on top of him and his face planted in the soil. He was unconscious and in full respiratory and cardiac arrest, not breathing and without a pulse.

After having to clear dirt and grass from plaintiff decedent's airway, emergency medical technicians began CPR and attempted to revive him with application of external defibrillators. Plaintiff's decedent was pronounced dead at approximately 7:28 p.m.

On Oct. 24, 2008, the Virginia Department of Social Services initiated an unannounced investigation of this facility and found "the facility failed to maintain a functional door alarm for its side exit door that is not normally used by residents to exit the facility."

[11-T-004]

Type of case: Negligence - assisted living - elopement

Injuries alleged: Wrongful death

Name of case: Confidential

Tried before: Mediation

Mediator: Thomas S. Shadrick

Date: Dec. 22, 2010

Demand: \$1,100,000

Offer: \$0

Verdict or Settlement: Settlement

Amount: Confidential

Attorneys for plaintiff: John E. Zydron, C. Stewart Gill Jr. and Catherine M. Six, Virginia Beach