91-year-old dies from fall after wandering outside of assisted living facility at 3:30 in the morning

Personnel failed to provide supervision for resident deemed at high risk for falls and injuries

Marty Thompson (not his real name) had always led a straightforward, active life. As a young man, he served in the U.S. Navy during World War II. After an honorable discharge, he went to work for a railroad company in the northeast and drove a train for 28 years. Following retirement in 1981, he moved to Florida and lived a pleasant and independent life. At the age of ninety, however, Marty suffered a fall at home, and his son John (not his real name) persuaded him to move to an assisted living facility which would allow Marty to continue living independently with on-site supervision to ensure his safety and well-being.

Marty was admitted to an assisted living facility in 2018. Its Senior Living Brochure promised the highest quality care for its residents. Shortly after arriving, an intake assessment concluded that Marty was unsteady, required a walker to move about, and needed supervision for all activities including routine daily living (bathing, dressing, medications). It also noted that Marty was at high risk for falls. As months passed, records included a progressive pattern of deterioration that included confusion, disorientation, insomnia, and wandering behaviors. Shortly after moving to the facility, Marty began suffering numerous falls, some of which resulted in hospital visits to suture wounds. No changes were made to Marty's care plan. His wandering escalated during nighttime hours and he repeatedly forgot to use his walker or wheelchair. He was clearly in danger of irreparable harm.

In September 2019, Marty was found at 11:00 p.m. wandering outside of the facility, attempting to cross a four-lane highway to reach a shopping center. Facility personnel escorted Marty back to his room. A few hours later, at 3:30 a.m., Marty again left his room, walked down long hallways past two unmanned nursing stations, and made it to the sidewalk outside the facility. He fell hard, damaging his right shoulder, arm, and knee. He lay on the sidewalk for an unknown duration screaming for help. A passerby called the fire department and emergency responders took Marty to a hospital. Examinations revealed that Marty had fractured his right arm. Police located the address of Marty's son and went to his home to wake him up. They notified him that his father was in the hospital and was severely injured after falling. The facility never notified John of his father's two efforts to leave the facility.

At 3:30 a.m., Marty again left his room, walked down long hallways past two unmanned nursing stations to the sidewalk outside the facility. He fell hard ... and lay on the sidewalk screaming for help.

The following day, John received a call from the hospital notifying him that his father had died from his traumatic injuries. Seeking to understand how this nightmare could have happened, he investigated the circumstances that his father endured at the facility. There had been no restraint on Marty despite having been noted as extremely high risk for falls, wandering, and confusion. Exit doors were locked to prevent ingress during hours the facility is closed. The doors were not locked for egress – exiting – in accordance with safety requirements to facilitate rapid evacuation. The facility's exit doors, however, were not monitored and residents at risk of wandering were not restrained. Marty's family had not received notification of the several injuries suffered by Marty's falls. John contacted Searcy Denney attorney **Karen Terry** and asked for help. Marty died as a direct result of the traumatic injuries he sustained in wandering unsteadily outside of a facility that had been responsible for his care. Ms. Terry filed a claim for Marty's wrongful death. The case was settled for a confidential amount. ◆