Interoffice Memo

To: Attorney Wynn More

From: Crystal Tucker, RN Legal Nurse Consultant

Date: May 9, 2023

Client: The Estate of John Doe

Type of Case: Wrongful Death (Nursing Home Elopement)

Re: Case Merit Review with recommendations

Introduction/Assignment:

You have asked me to review intake information submitted by Joe Doe about the death of his father. I am to review his allegations to determine the issues within those allegations, the merits of his claim, and the strength of his case, if litigation ensues. It is also necessary that I also determine any factors that the nursing home's counsel will argue or attempt to present as a defense.

Facts:

Mr. John Doe, a 77-year-old Vietnam veteran, was admitted to ABC Nursing Home. His past medical history is significant for strokes and heart attacks. He was wheelchair bound upon admission to the facility. On 4/20/2023 John Doe went missing from the nursing facility. The facility contacted his wife to ask her about Mr. Doe's whereabout.

The management of a nearby store was notified that the corpse of a male had been discovered in the parking lot near the trash cans. The police were notified. Mrs. Doe was not contacted and notified of Mr. Doe's death or the location of his body until between 6pm and 7pm that evening. Detective Gum Shoe of the Mayberry Police Department is assigned to the investigation of the case. Mr. Doe's son alleges that negligence caused his father's death and seeks to file a wrongful death claim against ABC Nursing Home, its governing body, administration, and nursing staff for damages.

Issue (s):

1. Whether ABC Nursing Home owed a duty of care to John Doe.
2. Whether ABC Nursing Home breached the standard of care in providing care to Mr. Doe.
3. Whether breaches in the duty and standard of care were the proximate and direct cause of Mr. Doe's death.

4. Whether ABC Nursing Home provided Mr. Doe with adequate supervision and assistance to prevent his avoidable elopement and death.

Brief Answers:

1. Yes. The duty of care is established when a resident is admitted to a medical or nursing facility. Mr. Doe was a resident at ABC Nursing Home.
2. Yes. An elopement is a sentinel and "never" event that placed a resident of a nursing facility in immediate jeopardy. The duty and standard of care was breached when Mr. Doe left the facility unaccompanied by staff and without the knowledge of the staff at ABC Nursing Home
3. Yes. Mr. Doe was unable to care for himself and could not receive necessary assistance and attendance during the time he was away from the facility to prevent injury and death.
4. No. ABC Nursing Home failed to provide Mr. Doe with adequate supervision and assistance to prevent elopement, injury, and death.

Analysis:

Issues:

1. Whether ABC Nursing Home owed a duty of care to John Doe.

2. Whether ABC Nursing Home breached the standard of care in providing care to ABC Nursing Home

3. Whether breaches in the duty and standard of care were the proximate and direct cause of Mr. Doe's death.

4. Whether ABC Nursing Home provided Mr. Doe with adequate supervision and assistance to prevent his avoidable elopement and death.

Legal Authority:

CFR §483.25(d) (1 & 2) Code of Federal Regulations (CFR) governing long- term care providers The facility must ensure that:

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

SC Code § 44-7-260 (2022)

"**Accident**" refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. This does not include other types of harm, such as adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current professional standards of practice (e.g., drug side effects or reaction).

"Avoidable Accident" means that an accident occurred because the facility failed to:

Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or

Evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or

Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or

Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.

Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision. A resident who leaves a safe area without supervision is at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, assault or being struck by a motor vehicle.

Various accidents and incidents have occurred with residents eloping from buildings including numerous situations that involved serious injury and/or death. (Tag F689) Elopement is a sentinel or "NEVER" event that places a resident in immediate jeopardy.

Each resident should receive an elopement assessment when they are admitted, when they experience significant changes and on a regular basis throughout the year.

It is of vital importance that all staff receive ongoing training regarding the elopement protocol to follow to prevent an elopement and for immediate response to a sounding alarm or the realization that a resident is not where he or she should be or cannot be located and may be missing from the facility.

The case for your client would be based upon the ability to show the following:

1. Failure to properly train staff on assessment and monitoring for residents at increased elopement risk.

2. Failure to recognize, assess, and address a resident's wandering behavior to prevent elopement.

3. Inadequate numbers of staff or inadequate staff mix such as too few licensed nurses.

4. Inadequate documentation regarding resident assessment, interventions, and care plans relating to wandering or increased elopement risk.

5. Failure to properly monitor residents increased elopement risk.

6. Having incomplete or inadequate policies and procedures for elopement prevention or for timely locating a resident following an elopement.

7. Failing to have adequate interventions consistently in place (i.e., door alarms, locked doors, security cameras, wander guards, etc.).

8. Failure of staff to timely respond to interventions (alarms, etc.) to prevent or promptly identify elopement.

The defense may attempt to "place Mr. Doe on trial" by bringing any cognitive deficits and behaviors that will show his as being physically or verbally, aggressive, a wanderer who was difficult to restrict or constrain to his living area. Counsel for the defense may also attribute the elopement to staffing challenges.

Conclusions:

ABC Nursing Home failed to provide Mr. Doe with adequate supervision and assistance to prevent his avoidable elopement and death.

Your client's claim presents a solid cause of action that ABC Nursing Home and its counsel will find difficult to defend as the elopement (Mr. Doe's departure from the facility) constitutes an egregious breach in the duty and standard of care. Even without the data and facts that would be gleaned from the medical records, death certificate, autopsy, and police report, along with all other recommended sources of information the facts of the elopement event are basis for a prima facie case of negligence and wrongful death. It is highly likely that Mr. Does family will prevail and be awarded damages.

Recommendations:

1. Interview of spouse and son of Mr. Doe by nurse consultant to determine more facts about medical history, admission to facility, and the events surrounding the elopement from the facility and death.
2. Obtain full medical records including diagnostic and laboratory tests, documentation of all disciplines involved in the care of Mr. Doe, the Minimum Data Set, Comprehensive care plan and other assessments located in facility chart.
3. Obtain copy of autopsy
4. Obtain copy of death certificate
5. Obtain copy of police report
6. Interview detective Gum Shoe
7. Interview store management where Mr. Doe's body was found

8. View video footage from ABC Nursing Home
9. View video footage from store parking lot where Mr. Doe's body was found
10. Obtain staffing roster of facility and unit where Mr. Doe lived on day of elopement
11. Obtain copy of incident report or report to the state as mandated by CMS
12. Obtain expert testimony of licensed nursing home administrator (preferably in SC)
13. Obtain expert testimony of a director of nursing of a nursing facility (preferably in SC)
14. Obtain expert testimony of a state surveyor, if necessary (preferably in SC)
15. Obtain expert testimony of maintenance department head of a nursing facility
16. Obtain copies of most recent facility survey
17. Obtain copies of most recent life safety survey
18. Obtain information about alarm system and any patient monitoring device
19. Obtain from ABC Nursing Home copies of 672 and 802 specifics to Mr. Doe
20. Inservice /staff education on elopement
21. Training files of key personnel directly involved in the elopement incident.