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75-year-old Manorcare resident wanders from facility, dies of exposure

CHICAGO, IL-It was a cold Chicago night on January 14, 2004 when 75-year-old nursing home resident, Davis Floyd was found lying face down on the street wearing only slipper socks, pants and a sweater. He was taken to Christ Hospital Medical Center where he died the next morning of hypothermia caused by exposure to the extreme freezing temperatures. At the time of his death, he had been a resident of Manorcare at Oak Lawn 95th (Manorcare) for six days.

Davis Floyd’s family selected Manorcare in order to help them manage his worsening dementia. Unfortunately, on that January night while the family thought he was safe in the nursing home, he was alone and wandering the streets of Chicago. The nursing staff did not know how long he had been missing.

When Floyd was admitted to Manorcare on January 8, 2004, the staff was made aware of his history of dementia, wandering and exit-seeking behavior. The staff knew they needed to take special precautions to protect Mr. Floyd from leaving the facility. The staff was also informed that he needed close supervision to ensure his safety. Floyd was at such high risk for wandering that an unidentified nurse placed an electronic monitoring bracelet on his ankle.

On the evening of January 14, 2004 at about 8:15 p.m., Davis Floyd was discovered to be missing. The temperature was approximately 21 degrees with a wind
chill factor ranging from 3 degrees to 12 degrees below zero. When the nursing staff noticed Floyd was missing, rather than immediately notifying the police, the nursing staff searched the facility for approximately ninety minutes. While searching outside at about 9:40 p.m., a staff member flagged down an Oak Lawn Police officer who was parked nearby. At about 10:23 p.m., a concerned citizen found Mr. Floyd lying face down on the street in front of 6308 West 94th Street (Chicago). Paramedics rushed him to Christ Hospital Medical Center where he was diagnosed with hypothermia. His body was shaking and he was suffering from chills, weakness and dizziness. Floyd’s core body temperature was 88 degrees. Despite efforts to warm him, Davis Floyd died the next morning.

Following Mr. Floyd’s death, the family contacted John J. Perconti of the Chicago law firm of Levin & Perconti to represent them and to investigate the circumstances of his death. After conducting an investigation, attorneys John J. Perconti and Patricia L. Gifford discovered that despite the nursing staff’s knowledge that Davis was at risk for wandering, there had been no interim plan of care in place to address his behavior. Although Mr. Floyd was wearing a monitoring bracelet, the nursing staff failed to notice that he had left the facility. Davis could only have wandered from the facility unnoticed if the electronic monitoring device was not operational or the nursing staff either did not hear or ignored the alarm when he left the facility.

John Perconti said: “The parties have decided to bring closure to this tragic event and have settled the case for $825,000. This untimely death and family loss was preventable and we strongly encourage all nursing homes to closely supervise and monitor their residents to protect them from dangers they cannot comprehend.”