

The Washington Post

Dozens of Assisted Living Residents Died After Wandering Away Unnoticed

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Dec. 17 at 6:30 a.m.

The alarms went off at 9:34 p.m. inside Courtyard Estates at Hawthorne Crossing, an assisted-living facility near Des Moines catering to people with dementia. A resident had wandered through an exit door, a routine event in America's growing senior assisted-living industry.

Automated texts pinged the iPads of the two caretakers working the night shift, and the phones of an on-call nurse and the facility's director. The warnings repeated every few minutes.

Though local temperatures were plunging toward minus-11, no one responded. The on-call nurse told investigators she ignored the door alerts because she was with her family. The caretakers said they didn't see them on their iPads. And they never followed through with hourly safety checks on memory-care residents.

At 6 a.m. — more than eight hours later — staff finally went looking for Lynne Stewart, a 77-year-old Alzheimer's patient with a history of wandering. They found her collapsed on the frozen ground near the exit, ice covering her body. She soon died at a nearby hospital from prolonged exposure.

"The thing I grieve the most is I tried everything I could for her to be safe," said Stewart's granddaughter, Kaylynne Van Rooy. "That's why she was there."

Stewart's death in January 2022 was not an isolated tragedy. Patients with Alzheimer's disease and other cognitive problems walk away from assisted-living facilities just about every day in America, a pattern of neglect by an industry that charges families an average of \$6,000 a month for the explicit promise of safeguarding their loved ones, a Washington Post investigation has found.

Since 2018, more than 2,000 people have wandered away from assisted-living and dementia-care units or been left unattended outside, according to The Post's exhaustive search of

inspection results, incident reports and media accounts nationwide. [Nearly 100 people died](#) — though the exact number is unknowable because no one is counting.

For many, the difference between life and death was simply the weather. In cases where a cause of death could be determined, The Post found that 61 percent died after exposure to extreme heat or cold.

Others died after wandering into ditches, drowning in nearby bodies of water or being hit by cars. Joseph Matthews, 77, perished from multiple organ failure after being found covered in fire ants and yellow jacket stings 20 hours after walking away from his North Carolina facility, his second disappearance. Jack Tribble, 79, wandered the woods near his South Carolina facility for nearly two weeks before dying in a pool of shallow water, according to a coroner's report provided to his widow.

The federal government does not regulate the nation's roughly 30,000 assisted-care facilities, as it does nursing homes. Instead, [regulation falls to individual states](#), few of which have adopted strong staffing and training requirements even as the industry estimates residents nationwide have climbed to more than 1 million, approaching the nursing home population of 1.2 million.

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Memory Inc.

Patients with memory problems walk away from assisted-living facilities just about every day in America; many die. The Post examines a pattern of neglect in America's [booming assisted-living industry](#).

See [how your state regulates these facilities](#) and read the [full investigation](#).

End of carousel

Recent growth in the \$34 billion industry has been driven in large part by demand for secure housing for the growing number of people suffering from dementia, a fragile population that now accounts for almost half of all residents in assisted living. These are also the residents at greatest risk of walking away: They can be confused but highly mobile, and some object to living in an institutional setting.

Many live in pricey "memory-care" units that pledge in marketing materials to maintain "safety systems and a well-trained staff" for "peace of mind"; "engaging programming" that "eliminates the desire to wander"; and staff "specifically trained to deal with this disease."

But state inspectors reviewing walkaway deaths have repeatedly found failures by administrators and front-line caregivers. In case after case examined by The Post, inspectors cited evidence of too few people on duty to care for the number of residents, of staff ignoring

alarms, of skipped bed checks and staff sleeping on the job, of general neglect and, in a few cases, falsified records.

These “elopements,” the industry term for when a resident leaves unnoticed and unsupervised, were repeated events at even some of the most luxurious facilities and continued to happen even after residents died or suffered catastrophic injuries.

Relatives of the dead and injured said they were unaware of the problem and had no idea [how to investigate the safety records of individual facilities](#). Only 29 states make complete and up-to-date inspection and violation reports available online, often on websites that are hard to find and difficult to use. In other states, residents seeking safety records have to file a public records request or contact the state’s long-term care ombudsman.

Some families were not told the truth about what happened to their own relatives, according to authorities and interviews. After Hazel Place, 86, was ignored for six hours in a sweltering Colorado courtyard in June 2021, for example, police records show her family was told she had “passed outside watching the sun set, an activity that she loved.”

Most states require facilities to report missing residents and preventable deaths, according to a Post review of records and [state regulations](#). But regulators have cited facilities more than 200 times since 2018 for failing to properly report missing residents — that’s 1 in 10 of the walkaways identified by The Post.

Authorities have charged lower-level staff with criminal neglect or falsifying records in at least four fatal incidents of this nature in the past five years. In a fifth case, they charged a line supervisor for ignoring alerts. Facilities and senior managers largely have not faced serious consequences, The Post found.

Regulatory fines seldom exceed \$10,000, the equivalent of about two months rent. When Arizona regulators determined that neglected resident checks led to the death of Ina Rose Jenkins, 88, in 104-degree heat in an irrigation ditch, the state said it fined chain-owned Silver Creek Inn the most it could: \$500. In three states — Connecticut, South Dakota and Wyoming — regulators have no power to levy fines at all.

[\[What questions do you have on assisted living?\]](#)

The biggest financial risk facilities face usually comes from lawsuits. Those are typically covered by operators’ insurance and settled for an average of about \$350,000 for a fatal elopement, according to an insurance company that underwrites them.

Most facilities declined to comment about incidents involving their residents. Leaders of the industry’s top lobbying groups did not dispute that residents with dementia sometimes exit facilities and die but said it’s a tiny proportion of the millions of assisted-living residents since 2018.

“While any fatal elopement is one too many, the issue should be considered within the context of the total number of residents served,” Michael Keegan, a spokesman for industry group Argentum, said in an email.

The group noted a difference between dementia-care units and other assisted-living units, which are less secure and allow many residents to come and go unsupervised. State regulators have cited both types of facilities for failures when residents suffering from dementia have walked away unnoticed.

“To be clear, we have no tolerance for bad care,” said Katie Smith Sloan, president and chief executive officer of LeadingAge, a Washington lobbying association for nonprofit senior-care operators.

“Any incidents where a resident was injured or worse are truly tragic, and we encourage assisted-living communities to have policies and procedures in place to help prevent and address these rare occasions,” agreed LaShuan Bethea, executive director of the National Center for Assisted Living. “If staff do not adhere to those policies and procedures, they should be held accountable.”

She said companies must also consider the desires of residents and families — as well as fire-safety regulations — regarding door locks and other security measures.

In a further written statement, NCAL spokeswoman Rachel Reeves said elopements are “rare” and for many the consequences are minor.

But for families paying to ensure a loved one’s safety, even brief moments of inattention can have devastating consequences.

“The one thing that my sister and I wanted was for our mom to be kept safe and for the facility to do what they promised and were paid to do,” said Susan Hoffer, whose mother, Lois Kathryn Cary, 82, died after wandering into a Michigan snowstorm two days before Christmas 2022.

“They failed,” Hoffer said, “and it cost our mom her life.”

NO FEDERAL OVERSIGHT

To determine the frequency and consequences of elderly residents walking away from assisted-living facilities in America, The Post searched local media reports and filed public records requests with regulators in all 50 states and the District of Columbia. The bulk of the official records came from 29 states that make current reports public online. Two additional states said they had no incidents; 10 did not provide records nor do they make them available online; some provided only partial records. As a result, [The Post’s accounting](#) is incomplete for about

40 percent of the assisted-living population. In some states, such as Florida, records don't always indicate whether a person died.

NCAL and its parent organization, the American Health Care Association, purchase data on safety and violations from consulting group NIC MAP Vision, which gathers information from the states. None make the data public nor would they provide it to The Post.

There is no national repository for government reports on assisted-living facilities, though the federal government has been aware of problems for decades. In 1999, a report by the Government Accountability Office documented safety problems — including a resident who climbed out a window of a supposedly secure Alzheimer's unit in Oregon and died from exposure. The agency reviewed two years of inspection records in four states, finding that more than a quarter of facilities had been cited for at least five quality-of-care violations, most frequently inadequate care, medication errors, low staffing and poor training. In Florida, the GAO found, deficiencies had been documented in 40 percent of facilities.

But the federal government has never implemented any standards or reporting requirements. Instead, Congress has created "work groups" with industry representatives to study the issues. One deliberated for six years about how to standardize and distribute crucial information to the public, including facility staffing and quality measures.

"We wanted to get away from the chandelier effect, which basically is that customers are driven by what a place looks like. And if a place has better chandeliers and better furnishings, therefore it must be better," said Deb Potter, a statistician at HHS, now retired, who led the group. "There's a whole body of research says it's not true."

The effort proved fruitless because of a lack of consensus.

"Assisted living is the rock we don't want to look under," said Catherine Hawes, a professor emeritus at Texas A&M University who has studied assisted-living quality for the federal government.

Bethea, of NCAL, said federal regulations would result in "rigid, national standards" that treat "every instance of dementia, and every person who lives with it, the same."

"Because each individual and each assisted-living community is unique," she added, "we believe regulation at the state level can better support person-centered care."

Federal lawmakers did pass one bill related to the industry, in 2008: It allows the tax-sheltered real estate companies that own some of the buildings to also profit from and make decisions related to operations.

Nursing homes are regulated as medical facilities, paid for mostly by Medicare and Medicaid. The assisted-living industry argues that it does not need to be as heavily regulated because it

primarily offers housing and meals, along with a menu of personal services such as help showering and toileting and frequent monitoring.

Residents and their relatives almost always foot the bill, making federal oversight politically challenging, according to experts and academics. Without the threat of withholding payments, “there’s no hook” for it, said Mark Miller, a lawyer at Legal Counsel for the Elderly, an affiliate of AARP.

“Families fall into a trap,” said Eilon Caspi, an assistant research professor at the University of Connecticut who specializes in long-term care. “They are paying a lot of money for peace of mind. When they get the phone call that their loved one is horribly injured or has died, they are shocked.”

‘DIDN’T TELL ME THE TRUTH’

[Regulation of assisted-living facilities](#) has been left to the states, which have struggled to enforce improvements, even at facilities with multiple walkaways.

In Florida, state reports show five residents have walked away from Woodmont Senior Living in Tallahassee since October 2020.

One man crawled out a window and was found walking along a highway, injured. Another was missing for more than 24 hours before being found “just down the road from the facility” washing himself in a park. Yet another was found by police at a bus station. When authorities called Woodmont hours later, staff didn’t know he was gone.

On Christmas morning 2020, 100-year-old Annie Lois Hanna was discovered dead on the ground outside Woodmont. A fire crew responding to a different emergency found her next to her walker and a blue pillow decorated with stars. Staff thought she was in her room. The cause of death was hypothermia, an autopsy found.

Kelvin Jefferson knew nothing about these incidents when he moved his 68-year-old mother, Bennie McGlockton, into Woodmont’s memory-care unit in April 2022.

Jefferson said he hadn’t the faintest idea how to research the facility or that the state posted inspection reports online. He wasn’t aware that state health authorities had threatened to strip Woodmont’s license after Hanna’s death.

Woodmont appealed the case, pausing state action as it worked its way through administrative courts. The company said it had retrained its staff to avoid a repeat.

In January 2023, two years after Hanna's death, staff called Jefferson to tell him that his mother had fallen and was in the emergency room. As he waited for a doctor, Jefferson said he pulled dirt and grass from his mother's mouth. Her dementia had progressed too far for her to tell him what had happened, he said.

Weeks later, Jefferson learned from a state report that the facility's door alarms were not working and that staff had not noticed his mother walking outside the night before. She was discovered the next morning near an air-conditioning unit by another resident peering out a window, according to the report.

Woodmont "didn't tell me the truth," Jefferson said. When the hospital released his mother, he did not take her back to Woodmont.

Woodmont also didn't report McGlockton's elopement immediately to the state, as required by law, according to the state report, "because the incident was not considered something the facility could have prevented." Two weeks after the incident, Woodmont struck a deal with state regulators, agreeing to pay \$61,500 in fines.

The facility was allowed to operate under a provisional license briefly until the property owner, Pacifica Senior Living, switched operators, according to state records. Pacifica, one of the largest assisted-living chains in the country, declined to comment.

'A WHOLE SYSTEM' FAILED

State oversight of assisted living is often [weak in several critical areas](#).

Only 13 states require a minimum number of on-duty caretakers per resident. Only nine require caretakers to obtain at least six hours of training in dealing with dementia patients, the minimum recommended by the Alzheimer's Association for workers at assisted-living facilities. And 21 states provide incomplete or no information online about violations.

In South Carolina, for instance, anyone considering the Palmettos of Bluffton near Hilton Head wouldn't know that Tribble, a retired Merck patent lawyer, had walked off undetected, apparently following a construction worker, according to state records. His body was found 14 days later less than a half-mile from the facility, lying in a swamp next to a pond.

Tribble's wife, Margaret, told police she paid for her husband of 51 years to live at the Palmettos because he suffered from auditory hallucinations and dementia. The facility is operated by National HealthCare, which did not respond to requests for comment.

In interviews, Margaret Tribble said a coroner's report indicated her husband had wandered alone for 12 days, dying two days before he was found.

“I’m so angry,” she said. “What I have found so very difficult is the way he died ... which I think could have been and should have been avoided.”

In an email, a South Carolina health department spokesperson said anyone can request facility inspection reports through the agency’s Freedom of Information Office. The agency charged \$324 upfront for records for two facilities. The documents took eight weeks to arrive.

Prosecutors have pressed criminal charges against staff in some of the more egregious walkaway deaths, including Stewart’s in Iowa, where staff knew she was prone to wandering. Just a few months before her death, she was found in the parking lot and a “wander guard” was attached to her ankle. The device was supposed to set off an alarm if she walked outside again.

On the night Stewart died, Catherine Forkpa was tasked with overseeing the 11 residents of the facility’s memory-care unit. Internal policy required her to check hourly on Stewart and others with severe cognitive issues, but Forkpa told state investigators she instead spent most of her shift dealing with an unruly male tenant.

It is unclear how long Stewart was outside in the freezing night. An alarm and texts signaling that her room door was open started going off at 4:23 p.m., about five hours before the exit door alarm was triggered.

Forkpa was fired and charged with second-degree murder. She pleaded guilty to a misdemeanor and was sentenced last month to two years probation. Her attorney declined to comment.

Polk County prosecutor Kimberly Graham said in a statement that she wanted to pursue charges against others at Courtyard Estates, but state law made it difficult. “Our office continues to look into all possible avenues to hold others accountable, and we will advocate for stronger and more effective laws involving abuse and neglect of dependent adults,” she said.

Van Rooy, Stewart’s granddaughter, said it didn’t make sense to blame just one person: “A whole system” failed, she said.

Stewart wasn’t the first person to wander away from Courtyard Estates. In 2016, a 92-year-old man was discovered lying in the grass several hours after leaving. He survived. The state fined the facility \$3,250.

And in December 2021, six weeks before Stewart’s death, a memory-care patient died at another Iowa facility run by the same company, Jaybird Senior Living. Elaine Creasey, 95, who had Alzheimer’s and used a walker, wandered away from Keelson Harbour, according to a state investigation, and died of hypothermia after nine hours in subfreezing temperatures.

Six days after Stewart died the same way, Keelson Harbour paid the state a \$6,500 fine for Creasey’s case — reduced from \$10,000, which state officials said is the standard discount for

facilities that don't fight citations. The state later fined Courtyard Estates \$6,500 for Stewart's death — \$800 more than Stewart's monthly fee to stay there.

In March, Iowa authorities cited another Jaybird facility, this one in Dubuque, after a resident wandered outside and suffered frostbite. The fine was \$4,000.

Jaybird operates 67 assisted-living facilities around the country. Each generates about \$2 million in annual revenue, according to documents and interviews.

Jaybird chief operating officer Justin Wray said the company takes elopements "very seriously." "The challenge is that you have people taking care of people," Wray said, "and at times individuals didn't follow the policies or the procedures set forth."

Nationwide, front-line assisted-living staff made \$15.39 an hour on average in 2022, according to labor think tank PHI, about the same as an entry-level retail job. Turnover is steep. [In dozens of interviews](#), staffers and former staffers said they were routinely stretched too thin.

Fire codes and ethical concerns make it difficult to keep doors locked, so staff must be scrupulous about heeding door alarms and doing head counts. Facility policies typically require staff to fully investigate when a door triggers an alarm — including looking outside, according to a sampling of inspection reports.

In many deaths examined by The Post, that didn't happen.

In Uniontown, Pa., where a 65-year-old woman died after wandering away and being hit by a car, employees told regulators they often ignored door alarms, assuming they were caused by employees entering the building. In an Arizona facility, inspectors reported that staff had covered the door alarm speaker and controls with masking tape.

In Troy, Ill., regulators said staff responded within three minutes to a 2 a.m. alarm, but the view from the window showed no footprints in the snow. The next morning, Kathleen "Kitty" Kinkel, 77, was found dead from the cold in a nearby field. Surveillance video shows chairs blocking the facility's exit door. Similar workarounds were noted in inspection reports in other states. In one California facility, staff tried to secure a broken door with trash bags and a tin can.

A report by insurer CNA in 2016 attributed elopement fatalities and injuries to a lack of vigilance, inadequate training and inaccurate risk assessments.

NO LICENSE REQUIRED

The elder-care industry has spent at least \$51 million lobbying state officials since 2017, according to Open Secrets, a nonprofit that tracks such spending in the 19 states that report it electronically. That does not include campaign contributions to elected state officials.

This year alone, the industry stifled proposed legislation to increase oversight of assisted-living facilities in Kansas and Delaware. It opposes a Massachusetts bill seeking new consumer protections for residents. And it is currently fighting a package of proposed regulations in Michigan that would increase oversight for smaller facilities, which make up the bulk of senior assisted living in the state.

Long-term care ombudsman Camille Russell said she was surprised when the Kansas bill “died overnight,” calling it “indicative of what happens when you have a well-connected industry to our leadership.”

The industry said every state’s political debates are unique. “There are many factors as to why pieces of legislation sometimes don’t make it through state legislative bodies,” Reeves, the NCAL spokeswoman, said in an email.

Michigan offers a case study in how the industry has avoided oversight. In 2017, the state adopted a measure that exempted some facilities from the state’s assisted-living licensing requirements if they paid an unrelated company to provide resident care. Industry representatives argued that such facilities shouldn’t be regulated if they provided only meals and housing.

One problem: The agencies providing resident care also are not required to have a license in Michigan.

In September 2019, Army veteran Robert Brunsten Sr., 88, left the secured dementia unit of Franklin Terrace, an exempted facility outside Detroit. Staff didn’t notice for two hours.

Twenty-nine days later, a search dog named Serenade prowling a brushy stretch of the Rouge River behind a nearby AutoZone caught the smell of decay. Two firefighters in a boat pulled a body from beneath a pile of debris. They identified Brunsten because his son had written his name inside his coat in case he got lost.

Because Franklin Terrace is not licensed, potential clients would not learn about Brunsten’s disappearance and death on the website of the Michigan Department of Licensing and Regulatory Affairs. “Most people just assume those places are licensed and have no idea they may not be,” said Alison E. Hirschel, director and managing attorney of the Michigan Elder Justice Initiative.

After Brunsten’s death, Michigan Adult Protective Services asked the state licensing division to consider revoking Franklin Terrace’s exemption, but the agency declined.

“Although there was a death that could have been prevented, there is no continuing risk to the health and safety of current residents,” a state inspector wrote, noting that the facility had switched care providers. Brunsten’s family settled its lawsuit against Franklin Terrace for undisclosed terms, and both declined to comment.

No Michigan lawmaker has proposed to eliminate the loophole. Its sponsor, former Republican state senator Marty Knollenberg of suburban Detroit, did not respond to a request for comment.

Meanwhile, lawmakers are debating whether to establish a system of fines of up to \$5,000 for Michigan assisted-living facilities of 20 beds or fewer. The measure would for the first time require caretakers at these facilities to receive dementia training.

The bill's sponsor, Detroit Democrat Stephanie Young, said she was ambushed this summer by a team of lobbyists and industry representatives on the porch of a luxury resort on Mackinac Island, where lawmakers were attending a policy retreat.

"They said, 'We really don't like this legislation.' And I said, 'I just bet you don't because it's about accountability and transparency,'" Young said in an interview.

Even licensed facilities in Michigan have been allowed to continue operating after repeated problems. Vista Springs Timber Ridge Village in East Lansing is still in business despite being cited 40 times in the past two years, including multiple findings of inadequate staff and an incident where a resident was locked out.

Lois Cary's daughters put her in Vista Springs in 2021 because the widow was suffering from dementia and could no longer live alone in her Sturgis, Mich., farmhouse. At the facility, Cary's condition worsened in ways that Vista Springs should have addressed, a state inspector later found.

Five days before Christmas 2022, Cary left her room at midnight, telling a staff member she wanted breakfast, an indication of confusion, the state inspector said. Two days before Christmas, she tried to walk out an exit door at 3 a.m. "to get a bird" in a raging Michigan snowstorm, according to a police account quoted by the state. A staffer redirected Cary to her room, but she emerged again 15 minutes later and was put back in her room a second time.

Staff didn't notice the third time she wandered from her room.

Four hours later, a snowplow driver alerted the facility that someone was lying in the snow-covered parking lot. The temperature was 7 degrees.

Staff found Cary near death, her fingers barely moving, according to the inspection report. A police report said her coat and clothing were soaked. Hoffer, her daughter, said in an interview that Cary was covered in snow and ice. After staff carried her inside, she was taken to the hospital, where she died.

The state investigative report listed multiple violations: Staff failed to conduct a routine bed check between 3:15 and 7 a.m. The facility did not update Cary's care plan to reflect a change in

sleep pattern and worsening confusion. And records for an unidentified staff member who had contact with Cary lacked evidence of training.

Despite the failures, six days after Cary's death the Michigan state investigator recommended that Vista Springs retain its license. Last month, prosecutors charged one staffer with a felony count of vulnerable adult abuse, saying the staffer "recklessly failed to act" to prevent Cary from going outside in the storm. She pleaded not guilty. Vista Springs did not respond to requests for comment.

"We don't know what they were doing with the amount of money our mom was paying," Hoffer told The Post. The fee was \$6,200 a month.

FALSIFIED RECORDS

In at least three incidents examined by The Post, family members said facility staff initially did not tell them the truth about what happened to their relatives. In at least two, authorities found that records were falsified.

When Hazel Place died in June 2021 at the Cappella of Grand Junction, Colo., a hospice nurse informed her family that Place had "passed outside watching the sun set," according to a hospice death report quoted in police case notes. Initially, police were not informed of the death.

In the days that followed, however, a former staff member called police, and Place's family told local reporters that they received a phone call urging them to ask for surveillance video — and an autopsy.

The surveillance video, which was obtained by The Post through a public records request, shows Place entering Cappella's unshaded internal courtyard shortly after 2 p.m. on June 14, strolling to a love seat and sitting down. Within minutes, she was slumped over in obvious distress. After two hours, Place stopped moving. The sun had pushed temperatures to 100 that afternoon.

Cappella expected staff members to check on residents in the courtyard, the facility administrator told state regulators, and Place's care plan required staff members to check on her every hour. Instead, Place languished in the courtyard for six hours until another resident's husband spotted her and alerted staff.

Staff falsely wrote in internal records that they checked on Place and applied medicinal cream on her legs as she sat alone, according to an investigation by the Colorado attorney general.

Christian Living Communities, the nonprofit chain that operates Cappella, declined to make an executive available for an interview. "We continue to hold Ms. Place's family in our thoughts

and prayers and sincerely regret this unfortunate incident,” spokeswoman Pam Sullivan said in an emailed statement. She said the facility “immediately placed on administrative leave” two employees who falsely claimed to have checked on Place and “added additional safety measures to ensure the well-being and safety of the older adults we have the privilege to serve.”

Through their attorney, Place’s children declined to comment. “The family’s claims against the facility have been fully resolved and at this time we’re no longer able to discuss this matter,” lawyer Chadwick McGrady said.

Two lower-level employees later pleaded guilty to charges related to neglect and received mostly probation. A third was acquitted.

The Colorado Department of Public Health and Environment issued nine citations against Cappella, and imposed a \$2,000 fine — the maximum allowed at the time. That equals about a week of Place’s care fees, which were \$7,600 per month, her family’s lawyer [told](#) local media. Last year, the state legislature [increased](#) the maximum fine to \$10,000 per violation, with higher fines possible for deaths or serious injuries.

A week before she died, Place had been found alone in distress in the same courtyard, according to the attorney general investigation and LaDona Luque, the former Cappella caretaker who said she found her. Luque, who is related to Place by marriage, said Place was confused, sweating and hot to the touch. Luque said she brought her inside, gave her water and warned the two caretakers on duty to keep a closer eye on Place.

The next day, Luque said she urged senior management to lock the courtyard door. Sullivan said via email that “there was no evidence or documentation of Ms. Luque’s claim of a previous incident” but did not directly deny that it happened.

“They knew the dangers of that door being unlocked. They knew,” Luque said. “That’s probably the most infuriating for me.”

“It was just a simple act of locking the door would have saved her life.”

The Washington Post is continuing to report on the assisted-living industry, and we want to know your experiences with elder care, assisted living and dementia care. [Tell us about your experience here.](#)

ASSISTED-LIVING RESIDENTS WHO DIED UNSUPERVISED

The Washington Post has identified 98 Americans with Alzheimer’s disease and other cognitive impairments who have died since 2018 after wandering away from assisted-living facilities or being left outside unsupervised. State investigative reports uniformly withheld the names of

residents, but The Post used public records and interviews to independently confirm their identities in most cases. They include a former construction worker and a former social worker; military veterans and homemakers; a tennis lover and a fishing aficionado; grandparents and great grandparents; a chemist and a four-time Super Bowl winner. Here are their names, with links to obituaries or other available information about their lives.

JOAN ACKLEY • REGINA ADAMIK • RUTH ALGUIRE • THELMA LORRAINE ARMSTRONG WRAY • DEBRA BARNES • LAWRENCE BEARSE • LAVINA BONACCI • ARMANDO BRAZZONI • ROBERT JAMES BRUNSDEN • LOIS KATHRYN CARY • FELIX CHARLES • ELAINE CREASEY • ROBERT CRISTALL • ANDREW DAVIS • SAM DAVIS • BARBARA DOYLE • BRENDA FERGUSON • ROBERT FREYMULLER • ANNE GACAMBI METHU • VERA MAY GOWER • ALTHEA GREEN • ANNIE LOIS HANNA • EUGENE HUGHES • JAMES HEDRICH • ORVAL 'BUD' HENGSTLER • MILDRED HERNANDEZ • MICHAEL HICKEY • RAYMOND HINKLE • VERONICA LASWELL HOFMANN • INA JENKINS • PEGGY JIROUSEK • JERRY JONAS • BARBARA JONES-DAVIS • MARIAN KEEFE • JERRY KENDALL • KATHLEEN 'KITTY' KINKEL • PATSY LINZMEYER • ANDREW LOUIE • ANNIE LEE LUCKETT • JOSEPH H. MATTHEWS • LADDIE JOEL MCKENZIE • ROBERT MCKINNON • KUM SUN MELCHER • JOAN L. MEREDITH • DORIS MITCHELL • YVANNE MOISE • AMY MORRIS • OZZIE MURPHY • BERTRAND NEDOSS • MARY O'SULLIVAN-SCHULTZ • PAULL PATTERSON • HAZEL PLACE • DWAIN 'DEWEY' POULIN • CALVIN POWERS • JANE RAILEY • CLAUDE ROGERS • TERRY ROLFE • JOYCE SALTS • ALAN SCHMITZ • EARL SIMSON • GARNER SOWLE • MARY JO STAUB • LYNNE STEWART • JOSEPH TALBERT • TOUFIK TANOUS • DAVID TAYLOR • HENRY THOMPSON • VIELACE RUDOLPH TIPPETT • JACK TRIBBLE • MICHAEL WALKER • FRANCIS WASHINGTON • JOE WELSH • GENE WILSON • IDA WOLK • BRIAN YODER • 23 UNNAMED

Methodology

The Post examined facility inspection data and incident reports from two-thirds of states and collected news reports from across the country, the first time a news organization has attempted to determine the national scope of wandering incidents and deaths among people living with dementia and other cognitive impairments in assisted-living facilities. Because 19 states do not allow reports to be downloaded by the public, and Nebraska and D.C. have not released new reports in recent years, the data presented by The Post is certainly an undercount.

To collect its data, The Post wrote computer programs to pull facility rosters and the number of beds available in every state, and to gather more than 160,000 available individual inspection reports since 2018 from the states that posted those reports online.

Using key phrases such as “elope,” “wander” and “missing,” reporters searched for cases where residents had left the facility without staff’s knowledge or had been left outside unattended.

They expanded their review into states without online inspection portals by scouring media reports and lawsuits and by filing public information requests with state agencies and local police departments. A second and third round of media searches were done by researchers and

reporters to try to provide the public with the most complete accounting of walkaways and walkaway deaths.

The Post's review included both general assisted-living facilities and the more secure dementia-care units. Many states have different names in their regulations for these facilities. The Post used a review from the National Center for Assisted Living to determine the different titles for assisted-living complexes.

The Post counted deaths involving residents with Alzheimer's disease or other cognitive impairments who got outside or were left unsupervised outside, including in vehicles. In one case, a resident was found in a stairwell. In another, the facility placed the resident in independent living although his contract required assisted-living oversight. The Post's review was not limited to deaths that led state authorities to cite facilities, but in 9 out of 10 cases where a resident died, inspectors did issue citations.

To examine states' oversight of assisted-living facilities, reporters gathered regulations regarding staffing levels, training and reporting requirements from each state. The Post then categorized each state into a tier of regulatory oversight based on benchmarks suggested by experts.

Finally, reporters used [data](#) from the American Seniors Housing Association ranking the 50 largest senior-housing owners. Reporters classified the companies on ASHA's list into general categories of ownership, to understand the business models underlying the assisted-living sector.

[About this investigation](#)

Memory Inc. Patients with memory problems walk away from assisted-living facilities just about every day in America; many die. The Post examines a pattern of neglect in America's booming assisted-living industry.

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