IN THE UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

In re	)	Chapter 11
LA VIE CARE CENTERS, LLC, et al	)	Case No. 24-55507 (PMB)
Debtors	)	(Jointly Administered)

SUBMISSION OF FOURTH PATIENT CARE OMBUDSMAN REPORT FOR CASE # 24-55507 (PMB)

PLEASE TAKE NOTICE that on July 18, 2024, Joani Latimer, the State Long-Term Care Ombudsman for Virginia, was appointed by the U. S. Trustee for the Northern District of Georgia Atlanta Division to serve as Patient Care Ombudsman in the above captioned case.

PLEASE TAKE FURTHER NOTICE that, pursuant to that appointment, I submit –the third Patient Care Monitoring Report (May 8, 2025 – July 7, 2025) is below:

Introduction:
The Virginia Long-Term Care Ombudsman Program consists of the Office of the State Long-Term Care Ombudsman (the "Office"), which is located within the Virginia Department for Aging and Rehabilitative Services (DARS), plus local program representatives employed by Area Agencies on Aging (AAA's) across the state that provide local program services under their agency's contract (Area Plan) with DARS. The local program representatives at the 20 AAA's that carry out the work of the Long-Term Care Ombudsman Program are designated and programmatically supervised by the State Ombudsman, Joani Latimer, who is appointed in the instant case as "Patient Care Ombudsman". During non-pandemic times, the Virginia Long-Term Care Ombudsman Program (LTCOP) Ombudsman Representatives ("ORs") visit residents of Virginia long-term care facilities quarterly when possible and may increase visits to specific facilities in response to complaints or as needed based on the conditions of the facility. In Virginia, the Office of Licensure and Certification of the Virginia Department of Health is responsible for licensure and regulatory oversight of nursing facilities, including nursing facilities operated by the Debtor.

July 8, 2025

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The Debtor, LaVie, is the governing body for:

Ashland Nursing and Rehabilitation Center	Ashland	VA
Augusta Nursing & Rehab Center	Fishersville	VA
Ghent Rehabilitation and Nursing *formerly* Consulate Health Care of Norfolk	Norfolk	VA
Consulate Health Care of Williamsburg	Williamsburg	VA
Windsor Grove Rehabilitation and Nursing *formerly* Consulate Health Care of Windsor	Windsor	VA
Consulate Health Care of Woodstock	Woodstock	VA
Grayson Rehabilitation and Health Care Center	Independence	VA
Kings Daughters Community Health & Rehab	Staunton	VA
Newport News Nursing and Rehabilitation Center	Newport News	VA
Pheasant Ridge Nursing and Rehabilitation Center	Roanoke	VA
Skyline Nursing & Rehabilitation Center	Floyd	VA

As noted above, in July of 2024, the U.S. Trustee appointed me in my capacity as Virginia's Long-Term Care Ombudsman, to serve as the Patient Care Ombudsman for the residents who live in these facilities. (See Notice of Appointment of Patient Care Ombudsman Filed by the United States Trustee on July 18, 2024.) Through the Office of the State Long-Term Care Ombudsman, I, as the State Ombudsman (referred to as "Patient Care Ombudsman"), serve to monitor and report on any concerns identified with the quality of long-term care services being provided by the Debtor to individuals residing in the facilities owned/operated by the Debtor. Onsite monitoring activities are carried out by our local program representatives who are charged with carrying out at the local level State Ombudsman responsibilities in protecting the health, safety, welfare, and rights of residents.

While the Patient Care Ombudsman role is more limited in scope than my duties as State Long-Term Care Ombudsman, it is consistent with normal duties and with the program's work to ensure a high degree of accountability from the facility owner/operator. The following information about the Debtor's operations with regard to its Virginia holdings reflects a compilation of observations and complaint handling activities related to the local program representatives' monitoring visits to facilities, as well as recent, objective, data driven information on the quality of the facilities' services from the CMS *Care Compare* website:

Ashland Nursing and Rehabilitation
(Historical Abuse Icon – CMS)
906 Thompson Street, Ashland, VA 23005-1128

Facility Monitoring Visits by the Ombudsman Representative (OR):

On June 9, 2025, the facility was visited by the OR, and she visited with 4 residents, the administrator, nurses, and the social services staff. The OR was informed by the Executive Director that she has hired two Activity Assistants, and one will be for the Memory Care Unit.

On June 23, 2025, the facility was visited by the OR, and she visited with 5 residents, the administrator, the nursing staff and the social services staff. The OR had a scheduled meeting with the VP of Consulate and the Social Worker.

Staffing:
June 9, 2025 - Two Activities Assistants have been hired – one of which is designated for the secure memory care unit. In addition, hiring an Activities Director was in process.

June 23, 2025 - The memory care unit had 27 residents and there was one nurse and one Certified Nursing Assistant (CNA) on duty at the time of visit June 23, 2025. In addition, the Vice President of Consulate noted awareness of administration changes needed and stated that the current Executive Director has been asked to leave. A new Director of Nursing (DON) will take the place of the current DON who will transition to Assistant Director of Nursing. The facility goal is to have the memory care unit staffed with three CNA's, one Nurse and one Activity Assistant.

Concerns:
On both visits, upon entering the facility the OR noted there was a strong odor. There did not appear to be any activities going on throughout the building and there were no activities on the calendar. Currently there is not an activities director or assistant on staff.

During both visits, upon entering the secured memory care unit, the OR observed residents sitting in the dining room alone with the television on but without audio or captions on. On June 9, 2025, residents stated they were hungry. At the same time, an alarm was going off and it appeared that the nurse on the floor did not hear the alarm. No CNAs were observed in the unit. During the June 23, 2025 visit at noon, the OR observed residents had not received their lunch. Further observations included the housekeeper in the memory care unit alerting the medication aide that a resident was on the floor which resulted in the nurse and the DON entering the room to assist the resident who was on the floor.

Actions Taken:
The OR asked the nurse about the alarm. The nurse said she did not hear the alarm. The OR asked the nurse if she could please check to see if the alarm was on that floor. When the nurse checked the alarm, it was for the funeral home outside of the locked unit. The OR asked the

nurse about staffing and the nurse stated that there were two CNAs on staff at the time but no CNAs were observed in the unit.

The OR discussed problems with care and services in the memory care unit with the social worker and Vice President of Consulate.

Complaint Investigations: Six complaints were investigated.

One resident's agent (Power of Attorney) was unable to access information on policies and obtain admissions papers copies that he had signed. With assistance of the OR, staff responded and provided the requested information.

The facility removed the bed rails needed for leverage for a resident to reposition and turn. This remains under investigation with OR working to resolve.

A resident experienced a lack of incontinence care and was left in wet clothing and wet bed. This remains under investigation with OR working to resolve.

Family expressed concern about the lack of resident supervision while eating due to swallowing issues. This remains under investigation with OR working to resolve.

Resident's representative was not notified of the time of care plan meetings and therefore is unable to attend. This remains under investigation with complainant noting difficulty in addressing the issue with administrative staff turnover.

One resident is unable to see well and needs new glasses. The OR is working with the facility social worker to arrange an eye appointment and glasses for the resident.

Additional Notes:
The OR has received general reports of lack of staffing and the air conditioning not working properly. In addition, an anonymous caller reported that *The Brief Interview for Mental Status* (BIMS) scores have been dropping due to lack of activities.

Augusta Nursing & Rehab Center
83 Crossroads Lane, Fishersville, VA 22939-2331

Facility Monitoring Visits by the Ombudsman Representative (OR):
On May 28, 2025, the OR met with the Executive Director and DON

Staffing: No issues or changes reported

Concerns identified: None. The residents appeared clean and staff members were noted

interacting appropriately with the residents during the provision of care. There was no indication of a decline in residents care since the last OR visit.

Actions Taken:
The OR addressed an issue with medication for one resident who requested OR check on his medications.

Complaint Investigations: One complaint was investigated.
The resident's family was not notified that the resident fell. The resident was in pain and the family's request to x-ray the resident for injury was ignored by facility staff. It was later determined that the resident had a fracture, but facility claimed the fracture was already present and disputed that the fracture occurred in the fall. This resident is now in another nursing facility. A report was made to the regulatory survey agency.

Ghent Rehabilitation and Nursing *formerly* Consulate Health Care of Norfolk
3900 Llewellyn Avenue, Norfolk, VA 23504-1203

Facility Monitoring Visits by the Ombudsman Representative (OR):
May 8, 2025, the OR visited the facility and toured two units.

June 6, 2025, the OR visited the facility and met with the administrator. in an effort to resolve the billing issue for a former resident.

Staffing:
In May, the facility hired three new licensed nurses, and the use of agency staffing has reportedly been discontinued.

Concerns:
The OR received no complaints from residents interviewed. There was no indication of a decline in residents care since the last OR visit.

Complaint Investigations:
The OR met with the administrator to resolve the billing issue for a former resident. The resident's insurance denied payment for one of the medications and the former resident was trying to find out why payment was denied. The administrator agreed to research the record and see if there is any indication of needing preauthorization for the medication.

Additional Notes:
Renovation work continues in the common areas and the residents' rooms. The OR interviewed several residents and did not receive any complaints that had not already been addressed by the administrator.

The OR met with the administrator and DON who stated there had been no issues with supplies.

The change to new ownership was expected on May 15th and the facility's new name is Ghent Rehabilitation and Nursing.

Consulate Health Care of Williamsburg
1811 Jamestown Road, Williamsburg, VA 23185-2326

Facility Monitoring Visits by the Ombudsman Representative (OR):
On May 9, 2025, the OR met with some residents, the Director of Nursing and Social Worker.
On May 15, 2025, the OR met with some residents, the Director of Nursing and Social Worker.

Staffing: No issues reported and none observed.

Concerns: The OR received no complaints from residents interviewed. There was no indication of a decline in residents care since the last OR visit.

Complaints Investigated:
Two complaints were investigated that did not involve lack of care or service by the facility.

Windsor Grove Rehabilitation and Nursing *formerly* Consulate Health Care of Windsor
(Historical Abuse Icon – CMS)
23352 Courthouse Highway, Windsor, VA 23487-5333

Facility Monitoring Visits by the Ombudsman Representative (OR):
On June 18, 2025, the OR visit included meeting with the Administrator, the Director of Nursing and several residents.

Staffing: No specific staffing issues were observed or reported.

Concerns: There was no indication of a decline in residents' care since the last OR visit.

Complaints Investigated: No complaints regarding this facility were received or investigated during this reporting period.

Consulate Health Care of Woodstock
803 S Main Street, Woodstock, VA 22664-1125

Facility Monitoring Visits by the Ombudsman Representative (OR):
On May 14, 2025, the OR visit included meeting with residents, the Administrator, nursing and activities staff, and a resident's family member.

On May 27, 2025, the OR visit included meeting with residents, the Administrator, nursing and activities staff.
On June 3, 2025, the OR visit included meeting with residents, the Administrator, nursing and activities staff.

Staffing:
The facility appeared better staffed than on previous visits by the OR. Hallways and resident rooms appeared clean and free of odors. There was no indication of a decline in residents' care since the last OR visit.

Concern:
During the May 14, 2025 visit, two residents were observed "parked" at the nurses' station and one resident was yelling at the other resident (who did not speak English). The second resident appeared distressed by this resident shouting at her and gestured for the OR to come over.

Actions Taken:
Regarding the above concern, the OR asked the nurse at the desk about the situation, who stated that both residents needed to be supervised and neither of them could be moved or separated and that this "happens all the time". The OR then went to the Unit Manager and explained what was happening and asked her to come observe the situation. The OR explained to the Unit Manager that the resident yelling was clearly in need of a quieter area and that the resident being yelled at was obviously distressed and that clearly being at the nurses' station next to each other was not an appropriate solution for either resident. The Unit Manager agreed with the OR and asked the agitated resident if she would like to "go for a walk" and she pushed her in her wheelchair down the hall. The resident who did not speak English appeared pleased to be left alone and said "thank you" in Japanese.

Complaints Investigated: No complaints have been received during this time period.

Additional Notes:
Overall, the facility seemed to have stabilized under the direction of the new director of nursing. There was no indication of a decline in residents care since the last OR visit.

A resident's family member stated he is pleased with the new doctors who have begun working at the facility.

Residents continue to dislike the food.

The fire alarm system tripped while the OR was present on May 27, 2025 due to painting in a room. Staff quickly responded by closing the doors and immediately inspected the panel to determine the location that triggered the alarm to clear the building of any danger. Within a couple of minutes, staff was able to announce over the speakers to all residents that the alarm was all clear and there was nothing to fear. The fire department visited and cleared the building.

Grayson Rehabilitation and Health Care Center
400 S. Independence Avenue, Independence, VA 24348-3972

No significant issues were identified or complaints received/ investigated in regard to the facility during this period.

Kings Daughters Community Health & Rehab
1410 N Augusta Street, Staunton, VA 24401-2401

Facility Monitoring Visit by the Ombudsman Representative (OR):
On May 12, 2025, the OR visit included meeting with several residents and staff including the Executive Director, Director of Nursing and Social Worker.
On May 13, 2025, the OR visit included meeting with several residents and staff including the Executive Director, Director of Nursing and Social Worker.
On May 22, 2025, the OR visit included meeting with a couple of residents and the Social Worker.
On June 25, 2025, the OR visit included meeting with residents and staff.

Staffing: No concerns regarding staffing reported or observed.

Complaint Investigations:
One case carried over from last period involved problems with resident's wound care, lack of pain medication, poor food quality and slow call bell responses. Adult Protective Services was also involved with the case investigation. Prior to completing the resident asked to withdraw her complaints. Per Program guidelines, OR intervention was withdrawn at resident's request. The resident stated that some things had improved.

Another complaint involving a resident with a pressure sore being left in his wheelchair for multiple hours with the call bell turned off was investigated. Adult Protective Services was also involved in this complaint. As of June 25, 2025, the resident reported being left in his wheelchair was no longer occurring. Staff is now assisting the resident in and out of bed per his requests.

Newport News Nursing and Rehabilitation Center
12997 Nettles Drive Newport News, VA 23602-6913

No complaints regarding this facility were received or investigated by the Ombudsman Representative during this reporting period.

Pheasant Ridge Nursing & Rehabilitation Center
4355 Pheasant Ridge Road SW, Roanoke, VA 24014-5272

Facility Visits by the Ombudsman Representative (OR):
On June 26, 2025, the OR visit included meeting with a resident, resident's family, and staff.

Staffing: No changes or issues reported or observed.

Complaint Investigations: Two complaints were received and investigated one involved resident's family's fear resident would fall out of bed which was addressed by the facility and the other involved assistance transitioning out of skilled care to home with supports in the home which was also resolved.

Skyline Nursing & Rehabilitation Center
237 Franklin Pike Road, Floyd, VA 24091-2893

Facility Visits by the Ombudsman Representative (OR):
Date(s) of visit(s) not available.

Staffing:
The facility administrator stated staffing levels remain consistent and that he is not utilizing any nursing agency staff in the facility. He expressed his opinion about the negative impact on resident care when using direct care staff from nursing agencies.

Concerns:
The OR has received no complaints regarding issues with quality of care. There is no indication of a decline in residents' care since last OR visit or most recent discussions with facility staff.

Complaint Investigations: No complaints received.

Additional Notes:
The facility administrator has consistently demonstrated his support with addressing residents' needs and has historically put systemic measures in place for resolving any issues that arise. During facility visits, this ombudsman has observed the administrator positively interacting with residents on a more personable level. The facility administrator has consistently demonstrated his support with addressing residents' needs and has historically put systemic measures in place for resolving any issues that arise.

The OR has been in contact with one family member who has been pursuing Long-Term Care Medicaid for the resident. The family member shared that the resident is receiving better care in this facility as compared to the previous facility where his relative had been placed. The family member shared that the business office manager has been supportive in efforts to obtain long-term care Medicaid for the resident including the business office manager going to the facility on a Sunday to fax the Medicaid application and supporting verifications for the Medicaid worker to review.

The facility administrator and Director of Nursing contacted the OR to discuss the barriers that they have encountered with accessing crisis mental health services through the local Community Services Board. They were willing to consider recommendations and suggestions to pursue appropriate mental health services for a resident with challenging behavior.

The OR observed the grass well-maintained, and no deterioration of the building to be notable. The facility administrator stated that he has obtained permission to replace the boiler system for the facility and anticipates the work will be done in the fall. He noted that the company installing the new boiler is requiring an advance partial payment be made before the work begins and he has received approval for the advance partial payment to be made. He explained that he does not anticipate any interruption with resident care since the company will be bringing a mobile unit during the changeover.

The administrator stated that he and his staff maintain sufficient care supplies to meet the residents' needs.

The OR observed the facility staff wearing new name tags, which the facility administrator noted reflects one of the steps taken in the restructuring of the management of the facility.

The facility administrator noted that there have been staffing changes in the management of the parent company but that these changes still allow him to make independent decisions relating to the management at the local level. He noted that there have been no adverse impacts on the functioning of the facility.

Conclusion:
Over the course of the past two months, the Patient Care Ombudsman has not become aware of any marked overall decline in facility conditions or resident care in the named facilities. As noted, Ombudsman Program representatives have intervened as appropriate on complaints and issues raised. These issues encountered across multiple facilities have not been of a nature or scope that suggests residents are at risk of harm, and in most instances, the ORs were successful in leveraging cooperation from leadership staff to resolve concerns in a timely manner. That said, in at least one of the facilities under court monitoring, in spite of facility leadership continuing to report significant efforts to shore up care staff and management/administration, there is not yet full resolution. Recognizing this, the OR has made efforts to conduct more frequent facility visits, but must balance those efforts against a broad range of resident needs and concerns in other facilities in the OR's jurisdiction that do not fall under this bankruptcy action.

Respectfully Submitted,

Joani F. Latimer, State Long-Term Care Ombudsman — Date: 7/29/2025

July 8, 2025