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 (January 8, 2025 – March 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.

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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
Consulate Health Care of Norfolk	Norfolk	VA
Consulate Health Care of Williamsburg	Williamsburg	VA
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):

January 8, 2025
January 20, 2025
February 7, 2025

(Each visit above included meeting with some residents and staff members including the administrator, nurses, direct care workers, housekeeping and dietary staff.)

Staffing:

- The facility is under new leadership and a number of key leadership positions are currently being covered by staff sent from corporate/ regional offices (e.g., Acting ED, Nathan Labassi from corporate office, and Assistant DON, Shalandrea McCain, from the regional office, who is filling in for a nurse manager).
- The facility administration reports efforts to address staffing shortages/ vacancies, including having hired 3 CNAS, 4 LPNS in the Memory Care Unit, plus an additional nurse and CNA, as well as HR staff.

Concerns:

- OR observed and reported to administrative staff that the medication cart on 100 Hall by the Nurses Station was unlocked with patient names left open on computer screen.
- In the Memory Care unit, there were 29 residents as reported to the OR and only 2 staff members on duty at the time of the walk through. Two residents had one-on-one attendant care. The OR observed one aide providing one-on-one care across the hall, and the Unit Manager standing at the door of another resident. The aide was going back and forth between the locked memory care unit and the floor outside of memory care unit. Meanwhile, a resident walked out of the locked unit with staff unaware. The OR was able to have the aide from outside of memory care unit redirect the resident back into the locked unit. The aide stated that the memory care unit door does not completely shut. The Unit Manager stated the door code needed to be changed. The Assistant Director of Nursing had Maintenance staff change the code.
- A resident had a bowel movement on the floor in his room. His Depends was off and the resident was walking around the bowel movement on the floor. After being asked to assist by the OR, an aide cleaned the floor and staff assisted the resident. OR observed a housekeeper in the unit.

Actions Taken:

- The OR addressed the concerns identified during the visit with the facility administrative staff and discussed steps to be taken to remedy the problems which included:
    - Staff will obtain a Wander Guard for the resident that left the memory care unit unnoticed.
    - Discussion on lack of staff needed to address the needs of residents in the memory care unity to ensure resident care and safety.
    - Request for lack of cleanliness in the memory care unit to be addressed.
    - Staff reported that the activities for residents in the memory care unit were being restructured.
    - OR will continue to monitor.
- The OR provided Residents' Rights Training in January for facility staff.

Complaint Investigation:

- The OR received a complaint in January regarding the facility's failure to effectively monitor and respond to symptoms/ change in resident's status, etc. The primary concern was that the facility's failure to assess and appropriately respond to changes and intervene appropriately (e.g., transfer resident to the hospital) placed the resident at serious risk. After multiple requests by the complainant to send the resident to the hospital, the resident was eventually sent by ambulance to the hospital and admitted. The OR arranged a meeting with staff and the resident's family to address their concerns regarding this incident. The Director of Nursing acknowledged some lapse in care protocol and noted they have provided additional training to staff.

Additional Notes:

- Staff on the skilled care unit stated communication has been better since past executive director left. The nurses praised the Nurse Manager.
- Dietary staff stated supplies are arriving but noted that the Monday delivery has been slow.
- Housekeeping stated that there are enough supplies with no issues ordering any needed supplies.
- Residents stated they are receiving showers, and the food is good and filling. One resident praised her nurses.

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

Facility Monitoring Visits by the Ombudsman Representative (OR):

December 11, 2024 - (this entry was not included in the prior report) OR met with some residents and the administrator. The facility was undergoing an OLC survey.
February 26, 2025 - OR visited the facility meeting with some residents and Kemper McCauley, head of the Skilled Nursing Unit.

Staffing:

- OR was informed that a new Director will likely be in place in a number of weeks, but according to the interim acting Director, they are having difficulty finding a qualified person.
- The Social Work Department Director is no longer employed, but an assistant is in place. The administrator was seeking to fill the "social work director" position.
- The facility is under the purview of Alyssa Clark, V.P. of Area Operations, who was in the building the day of a visit. The OR, however, did not have the opportunity to speak with her.

Concerns identified: None

Actions Taken: None needed

Complaint Investigations:

- There were no new complaints during this visit and there was no indication of a decline in resident's care.

Additional Notes:

- Residents interviewed expressed no concerns. One thought 'things were getting better.'

Consulate Health Care of Norfolk
3900 Llewellyn Avenue, Norfolk, VA 23504-1203

Facility Monitoring Visits by the Ombudsman Representative (OR):

February 10, 2025 - OR met with the administrator and a few residents and toured the facility.
February 26, 2025 - OR met with the administrator and management staff and toured the facility.

Staffing:

- There have been no ongoing problems providing care to the residents in a timely manner according to the administrator.

Concerns:

- The OR received no complaints from residents interviewed.
- No concerns were observed. The residents appeared clean and staff members were noted interacting appropriately with the residents during the provision of care.

Actions Taken:

- OR requested an invitation to the next Resident Council meeting.

Complaint Investigations:

- No complaints have been received.

Additional Notes:

- During the last visit, the OR observed evidence throughout the facility of improvements to the physical plant. Renovations were going on without any delays. The administrator did not mention any problems in getting supplies for routine care nor in getting contractors to work on the physical plant improvements.
- The OR was informed that there are plans to change the facility name within the next couple of months.

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

Facility Monitoring Visits by the Ombudsman Representative (OR):

January 8, 2025 - OR visited the facility meeting with a number of residents and staff members including Human Resources, Dietary, Activities, Memory Care, Finance and Social Services.
January 10, 2025 - OR facility visit included a complaint investigation.
February 10, 2025 - OR met with the administrator and some of the administrative staff.
February 28, 2025 -OR visited with administrative staff and staff from Human Resources, Therapy, Nursing, Memory care, as well as facility residents.

Staffing:

- Various staff departments mentioned difficulty with keeping sufficient staff, which had been a problem even before the bankruptcy proceedings. Dietary staff stated it takes a long time to get background checks.

Concerns:

- Residents reported they were fine with their care. No new problems or issues were reported. Residents appeared clean, and the staff members appeared to be appropriately interacting with the residents during the provision of care.
- Staff reported no concerns. There was no indication of a decline in residents' care and no new complaints.

Actions Taken:

- OR requested an invitation to attend the next Resident Council meeting.

Complaints Investigated:

- The OR received a complaint concerning a resident in skilled care not receiving medication the hospital ordered. It was noted that since the resident's surgery prior to placement in skilled care, the resident appeared to be experiencing some cognitive issues. The resident stated that someone was trying to get the keys to his house. After visiting the resident on January 10, 2025, the OR investigated the identified concerns. The OR's investigation of both issues did not reveal deficient practice on the part of the facility as there were underlying facts that made sense of what had occurred, and the complainant was informed of the results of the investigation.

Additional Notes:

- The OR observed evidence throughout the facility of the improvement to the physical plant since the last visit.
- The administrator did not mention any problems regarding getting supplies for routine care or getting the contractors that are working on the physical plan improvements. The

OR was told that there are plans to change the name of the facility within the next couple of months.
- Therapy received a new supply of walkers of all types.
- Administration stated there was an estimated date at the end of March for conclusion of bankruptcy, with anticipation of a new corporation takeover, change of name, etc.

Consulate Health Care of Windsor
(Historical Abuse Icon – CMS)
23352 Courthouse Highway, Windsor, VA 23487-5333

Facility Monitoring Visits by the Ombudsman Representative (OR): February 25, 2025

Staffing: no update

Concerns:
- Administrator noted that the facility is still experiencing a delay in processing invoices. This, however, reportedly has not had any negative effect on the care and services provided by the facility.
- Residents interviewed had no complaints. There was no indication of a decline in residents' care.

Actions Taken: None

Complaint Investigations: No complaints received.

Additional Notes: None

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

Facility Monitoring Visits by the Ombudsman Representative (OR):

January 10, 2025 - OR visited with some residents, the administrator and the nursing staff.
January 15, 2025 - OR visited the facility to meet with the Resident Council to assist with their request for help in writing bylaws. The OR also met with the activities director and the administrator.
January 22, 2025 - OR visited with some residents and the administrator.
January 28, 2025 - the OR visited with some residents, the administrator and a few others present.
February 4, 2025 - OR visited with some residents, the administrator and the nursing staff.

February 13, 2025 - OR met with some residents and a few staff members including the administrator, the activities staff and the social services staff.

February 24, 2025 - OR met with some residents and a few staff members including the administrator and activities staff.

March 3, 2025 - OR visited with some residents and a few staff members including the administrator and the nursing staff.

Staffing:

- On January 10, 2025, the OR learned that the Director of Nursing (DON) had left the company after they stopped paying her travel expenses. There was an interim DON at the facility, who stated that the position was temporary for her.
- There had been ongoing issues with the DON position. The interim DON has tried to hire new DONs without the administrator's consent, and the applicant selected had no long-term care experience and was not familiar with the regulations, so she was dismissed. There were more interviews happening for a new DON, but no decisions yet made. The failure to successfully recruit/ hire a qualified DON to provide stability and leadership in this critical role is an ongoing concern.
- As of February 4, 2025, there was still no permanent DON, just a new acting DON due the next week for 1-6 months.
- On March 3, 2025, the OR observed at least three care staff on each hall. Clinical staff reported that they were stressed and did not feel supported by their corporate leadership. There was still a temporary DON, and the administrator reported that she was still trying to hire someone with experience.

Concerns:

- There were no new food issues, but the administrator still feels the dietary services vendor leaves a lot to be desired. Throughout the multiple visits, staff identified food services as the major issue reporting that no matter how much the administrator and the OR reach out to the director of service, there is no improvement.
- Concerns were expressed regarding the kitchen manager having her children in the kitchen again on the weekend. It was reported that meals are still being served cold occasionally. It was noted that there are meals being served that provide little or no protein (example: Macaroni and Cheese with green beans).
- The facility is aware that they need new pipes installed, but they have not been able to get such a large expense passed through the corporate office. Some residents report not having hot water in their bathrooms, (only lukewarm water).
- During the visits, there were no new complaints received by the OR and no indication of a decline in resident's care, until January 28, 2025 when it was reported that on Thursday afternoon (January 23, 2025) a pipe had burst in the ceiling of the Rosewood hallway, between the activities room and the nurse's station. Several resident rooms were flooded and the entire hallway had to be cordoned off until the ceilings and other damage could be replaced. As a result, several residents were displaced to a sister facility or to their family homes temporarily until their rooms could be restored. Of

those who were sent out to a sister facility, many have since returned to the facility, sharing private rooms as 'semi-private'. Because residents found the non-smoking nature of the other building unacceptable, they fought to return. The police were called by complainants on several occasions during this process with no fault attributed to the facility actions. The dining room (also on the affected hall) is filled with the residents' beds and belongings from the affected rooms and all meals are being taken in the residents' rooms or the dining area of the locked unit. Smoke breaks and outside time are also being taken in the locked unit's courtyard since the affected hall also was the residents' access point to the main courtyard. Building inspectors have been involved working to determine which parts of the hall can be opened and what work must be completed to make that hall safe for residents again. There was no indication of a decline in resident's care.

- During the February 13, 2025 OR visit, the administrator reported that the facility was issued a citation from the Fire Marshall, resulting in the need for new exit signs and updates to their evacuation plans. The heat was out in the lobby and in the administration offices, however, the resident rooms still had heat.
- As of February 13, 2025, the building repairs had not yet begun due to licensing issues for the company chosen. However, on the February 24, 2025 OR visit, construction had started on the hall that had sustained the water damaged from burst pipes and the insulation has been inspected and approved so that drywall work could proceed.
- During the March 3, 2025 OR visit, the administrator noted that the boiler was leaking, which was causing the water damage to an adjacent wall. The corporate office had already approved an invoice for the company that installed the boiler, and repairs were expected the following week.
- Throughout the visits, there were no indications of decline in resident care.

Actions Taken:

- OR assisted the Resident Council in writing by-laws.
- OR provided a resource to staff to assist with a resident with mental health issues.
- After the pipes burst, and residents or families called the police during the relocation process, the police visited the facility to discuss how to best serve the residents of this facility without becoming their go-to first call every time. The OR provided information to the police to ensure the police were aware of the residents' rights.
- During the February 24, 2025 OR visit, residents advised the OR of their concerns that the temporary Director of Nursing (DON) was attempting to take away residents' rights such as smoking. The OR explained to the DON sharing regulations and policies pointing to the fact that the residents who are admitted with smoking privileges cannot have them taken away with which the administrator concurred, but the DON opposed.
- Also, during the February 24, 2025 visit, the OR observed a resident undressed on their bed with no staff nearby and their door wide open. The OR reported this to the administrator, and she agreed that it was a dignity issue, and stated that the resident should not have been left that way. She had the issue immediately addressed.

- During the March 3, 2025 visit, the OR observed a section of wall in the memory care unit where the kickplate has separated from the wall. She reported this to the administrator so that the contractors could repair it. In addition, an area observed to potentially have mold was reported to the administrator who sent staff to inspect it.

Complaint Investigations: No complaints received.

Additional Notes:

- By February 4, 2025 visit, all but one of the displaced residents had returned to the facility after the flooding. The administrator had two estimates for the repairs and plans to hire one of the companies soon to get the rooms back in livable conditions. The activities room had been cleared by the building inspector, so residents were pleased to be able allowed to visit the activities area again.
- Surveyors were in the facility prior to the February 4, 2025 OR visit. The facility received one cited deficiency for improperly documenting administration of medication that was not given. The facility staff were given a stern warning from the surveyor to make sure that nothing is documented that has not already been done, and to do frequent medication audits. The administrator appeared to be taking this very seriously.
- During the March 3, 2025 OR visit, construction was observed underway with a building permit posted on the front door.
- Residents appeared to be adjusting well to construction and the current layout (detour path) which involved them passing through memory care unit safely. Residents did not share any concerns with the OR.

Grayson Nursing and Rehab Healthcare Center
400 S. Independence Avenue, Independence, VA 24348-3972

Facility Monitoring Visit by the Ombudsman Representative (OR):

March 6, 2025 - OR visited the facility meeting with a few residents and family members as well the administrator, the nursing staff, direct care staff, activities staff, housekeeping staff, dietary staff, social services staff and a few others.

Staffing: Staffing remains stable.

Concerns:

- None noted. Residents reported satisfaction with care and being able to have concerns addressed by management. Building appears well kept with adequate food and supplies. There were no indications of a decline in residents' care noted.

Actions Taken: None

Complaints Investigated: No complaints received.

Additional Notes:

- The OR was informed that the facility will be rebranding May 1, 2025. The Grayson Rehab facility's name will change to Avardis Health.

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

Facility Monitoring Visit by the Ombudsman Representative (OR): January 15, 2025

Staffing: No comments.

Concerns:

- Lack of appropriate wound care, symptoms unattended. See Complaint Investigations section below.

Actions Taken:

- The OR spoke with the administrator about the facility's pressure ulcers prevention practices and lack of appropriate wound care as evidenced in two complaint investigations.
- The OR assisted family members of residents harmed by lack of wound care to file complaints with the survey agency.

Complaint Investigations:

- On January 13, 2025, the OR received a complaint regarding a resident in the skilled care unit who developed a stage 3 pressure sore. Due to a choking incident, the resident was sent to the hospital where the Emergency Room (ER) physician determined that the resident's kidneys were shutting down and she needed dialysis immediately. The ER physician reported the ulcer was very large and shared his opinion that the resident must not have been regularly repositioned. The complainant's concerns included not being informed of the resident's change in condition and the drastic ulcer/wound wrapping around the resident's right side. APS conducted an investigation for possible neglect, but the report was deemed invalid because the resident was not in danger since, at that point, the resident was in the hospital and no longer at risk in the facility. The OR spoke with the administrator regarding wound prevention and wound care concerning this situation and one other lack of wound care complaint. The investigation determined the facility had not taken appropriate action to address the resident's risk of developing pressure ulcers – e.g., repositioning and/or use of a pressure relieving mattress prior to wound development. The OR conducted staff interviews and records review to learn how the resident got pressure wounds and if staff were aware of the severity of them. (This was important information, both in terms of the individual complaint investigation and the potential implications of the finding with regard to other residents that could be similarly at risk of skin breakdown.) It was determined

that the resident did not refuse repositioning. Wound care notes documented on December 19, 2024 stated staff noticed a possible stage 2 ulcer. The pressure relieving mattress was ordered on January 3, 2025. The wound care specialist documented that there was a decline in the wound on January 2, 2025 when three wounds combined into one large wound. Notes also revealed that two of the initial wounds were caused by removing the adhesive tape on the first wound.

- An additional case was reported to Adult Protective Services (APS) of a resident sent to the hospital on January 11, 2025 with a stage 4 wound on his tail bone, who was in septic shock (possibly from his pressure wound receiving inadequate care). Hospital staff reported that the resident's dressing had not been changed any time recently, noting that it was one of the worse sacral wounds they had seen. Hospital staff expressed concern that the nursing facility had not been providing appropriate care. Facility staff reported the dressing was changed daily and the resident often declined repositioning. The OR talked with a family member who reported that the nursing facility wound nurse had informed him the resident's wound was healing. The complainant reported that the resident was not bathed or repositioned in a timely manner. The resident passed away at hospital on January 14, 2025. The APS worker initially substantiated neglect of this resident, but the final report indicated the complaint was 'unfounded' since the resident was deceased and the investigation was closed. Complaints were filed with the survey agency. On January 27, 2025, the facility sent the OR a copy of a Facility Reported Incident form that noted the internal investigation did not substantiate neglect, but the facility identified the need or better documentation and a need for a different wound care service provider.

Additional Notes: None

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

Facility Monitoring Visits by the Ombudsman Representative (OR):

February 18, 2025 - OR visited the facility speaking to many residents as well as the administrator, nurses and other staff.

March 5, 2025 - OR visited the facility and spoke with a number of residents and a family member in addition to the facility administrator, nurses, and social services staff.

Staffing:

- OR interviewed the Director of Nursing who reported staffing has increased.
- On March 5, 2025, the new Social Work Director and Assistant Social Worker had started in their positions that week.

Concerns:

- On February 18, 2025, no concerns were noted. Residents were engaged with activities and had no complaints. There was no indication of a decline in resident care.
- On March 5, 2025, a couple of residents complained about staff shortages but requested the OR not address their complaint.

Actions Taken:

- On February 18, 2025, one resident interviewed by the OR had not received a toilet tank lid that had been ordered months ago. The resident had a plastic lid cover that did not fit properly. The OR brought this to the attention of administrative staff who agreed to look into it the same day and determine if the lid needs to be reordered. On March 5, 2025, staff shared that the entire toilet had been replaced with a new toilet.

Complaint Investigations: No complaints were received.

Additional Notes:

- OR was informed by the Interim Administrator that all vendors have been paid as scheduled with no concerns. The supply coordinator shared that supplies have been coming in with no issues. The new maintenance supervisor stated that vendors continue to work with the facility but noted that some vendors had stopped.

Pheasant Ridge Nursing & Rehabilitation Center

4355 Pheasant Ridge Road SW, Roanoke, VA 24014-5272

Facility Monitoring Visits by the Ombudsman Representative (OR):

January 17, 2025 - OR visited the facility in response to a family complaint that the resident was not receiving showers or therapy services as scheduled.
January 29, 2025 - OR visited the facility speaking with residents and staff.
February 18, 2025 - OR visited the facility for monitoring and complaint investigation.
February 24, 2025 - OR visited the facility and met with the regional director and family member complainant.

Staffing:

- On January 29, 2025, the OR was advised that a new administrator had started working at the facility the day, and that a new interim Director of Nursing (DON) was working in the facility filling the DON position until the vacancy is filled.

Concerns:

- No decline in resident care was observed in January.

Actions Taken: See complaint investigations section below.

Complaint Investigations:

- On January 17, 2025, the OR visited a resident who expressed concerns that he would like to shower but the stretcher used is very uncomfortable. He stated he receives a bed bath occasionally. The resident also stated that he was given therapy two days and then it was discontinued. The OR interviewed the Director of Nursing (DON) who shared that the resident has refused showers/baths on multiple occasions. The OR requested documents from the DON, and she said she would send them. The Therapy Director was not able to provide any information at the time of the visit. The resident desired to move to another facility. A meeting was held in February with resident's friend, family members and facility staff to resolve resident's additional concerns while he remained in the facility. Plans developed included staff education on customer service, daily plan to get resident up out of bed and to a wheelchair daily, and the DON added a reminder on her calendar to change the resident's catheter every 28 days as ordered by the physician.
- On February 18, 2025, the OR received a complaint alleging neglect of a non-verbal resident who had a stroke and has been left in soiled briefs for extended periods of time. Complainant also stated the resident had not been given showers as scheduled. The complainant shared that he must provide care for the resident because the facility was short staffed, and staff present were not adequately trained. Additionally, the resident reportedly needs to be seen by podiatry which has not happened. The facility provided the resident with physical therapy, occupational therapy and speech therapy daily. The complainant also had arranged for an additional speech therapist to come into the facility to work with the resident. The OR visited the resident and observed him to be clean, appropriately dressed and groomed seated in his wheelchair. The complainant was present during the visit and spoke with the OR stating no one was taking proper care of the resident. The OR proceeded to interview staff who indicated some things have improved for the resident, but the complainant does not agree. Adult Protective Services (APS) was also investigating the allegation of neglect. The OR and complainant met with the regional clinical services director on February 24, 2025 to discuss concerns and develop action plans to improve the resident's experience at the facility. A plan was developed involving staff placing a stop sign on the resident's door to keep wandering residents out of this resident's room, and staff providing therapy goals and updates to the complainant weekly. The Unit Manager was designated to be the point of contact for the complainant. The complainant was informed that he can also call the clinical regional director at any time with concerns. On March 3, 2025, the OR received a call from the complainant reporting that he felt the prior meeting was a waste of time and unproductive. The complainant stated that he has seen no improvements in any of the plans that were set during the past meeting, and that the clinical regional director was ignoring him and not addressing him in the hallways. The complainant stated that he was working to get the resident moved to Florida with him as soon as possible, and he planned to file a report with the survey agency for which the OR provided contact information.

Additional Notes: None

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

Facility Visits by the Ombudsman Representative (OR):

January 24, 2025 - OR visited the facility and met with the administrator, social services staff, and a resident who will be returning home soon.
March 7, 2025 - OR visited the facility, speaking with 2 family members, the administrator, nursing staff and the social services staff.

Staffing:

- The administrator noted that a few staff resigned, but this has not affected the provision of care to the residents. He reported new staff will be hired to fill the vacant positions. The Director of Nursing was not currently working due to illness but will return when her health improves.
- Staffing consistency / stability appears to have improved after the facility's challenges with the rise in COVID positive cases and other respiratory illnesses. The facility administrator conveyed to the OR that they were recruiting and training direct care staff, but were disappointed with the final number of staff employed after the training. He was working with the CNA class instructors at local high school to recruit potential care staff since the high school students have completed their clinical work in the facility. He noted that, unfortunately, he was unable to hire many of the high school students due to the age requirements.

Concerns:

- While the overall resident care does not appear to have declined, there seems to be a systemic issue with the direct care staff's consistency in providing personal hygiene care. The Administrator has informed the OR that he, and the Director of Nursing, are implementing an enhanced response to resident care needs by holding the direct care staff and nursing supervision more accountable for the provision of care. He noted that they will be taking a firmer stance with disciplinary action if needed.

- OR observations indicated no decline in resident care. Some residents had COVID and their rooms were observed to have sufficient PPE supplies outside of their doors with precautionary signage for entering the room and the requirement for donning face masks and awareness of contact precautions. In addition, at the facility entrance, there was signage advising all to where masks due to COVID.

Action Taken:

April 8, 2025

- Resident interviewed revealed a need for services when she returns home. She needed to apply for Medicaid in-home services and supports. The OR assisted the resident to communicate her wishes to complete a Medicaid waiver application to facility staff. Staff was responsive in assisting the resident.

Complaint Investigations:

- In a previous care plan meeting, resident family members met with facility staff to discuss their concerns about the lack of appropriate incontinence care. The Director of Nursing (DON) subsequently arranged for direct care staff to accurately document the number of times that incontinence care was provided to the family member. The DON created a notebook for the nursing supervision staff to verify incontinence care was documented each time that care was provided. During a meeting with facility staff, family members and the ombudsman on March 7, 2025, family members provided the facility Administrator, DON, and facility Social Worker with documentation of their observations when the resident was not provided incontinence care within the two-hour timeframe. In response, administrative staff reported implementation of an additional recording system/ supplemental tab in care tracking database (i.e. "Point-Click-Care") for monitoring of provision of care for activities of daily living. The Administrator confirmed that he and the DON are implementing systemic/internal changes to ensure consistent assignment of direct care staff in specific areas of the facility and further steps to ensure the nursing supervision staff is accountable for the supervision of direct care as needed for the residents.

Additional Notes:

- Facility administrator stated that he has been adding to his stock of supplies for the facility as he is permitted to spend funds from the facility budget. He expressed confidence in having adequate supplies, as needed, for now and for the future. No problems with acquisition of supplies as needed was noted.

- Facility nursing/health care staff have implemented additional care interventions due to positive cases of COVID in the facility. Residents are recovering well with additional skilled nursing services.

- Facility administrator conveyed to the OR that the issues associated with the parent company relating to the bankruptcy are progressing toward resolution with the expectation of completion by April 2025. He noted that he does not expect that the name change will not adversely affect the operation and functioning of the facility.

- Residents' family members expressed their comfort with informing facility staff of their concerns but do not feel that changes are being made in a timely manner. Family members expressed the opinion that it was difficult to connect with the administrative staff in as reasonable amount of time as they desire. Some family members have

conveyed to the OR that they do feel heard by the facility staff when they express concerns.

- There are no notable concerns with the condition of the building or any notable deterioration in the structure at this time.

- The Administrator confirmed to the OR that he has adequate supplies/food to meet the residents' needs. He noted that he has stored sufficient supplies (e.g. nasal cannulas, undergarments, etc.) to meet residents' needs. The Administrator noted that he also has sufficient petty cash to address facility needs as they arise.

Conclusion:
Since the date of the appointment, the Patient Care Ombudsman is not aware of marked overall decline in facility conditions or resident care in the named facilities. That said, it is notable that the program received and investigated a number of serious complaints regarding the quality of resident care and that these complaints were not limited to a single facility. There is cause for concern related to complaints about instances indicating a lack of appropriate care to maintain skin integrity that had led to severe and even life-threatening pressure sores. Additional concerns were investigated relative to inadequate daily hygiene care for residents which in some instances appeared to relate to the lack of sufficient numbers of competent staff on duty. There were explanations from administrators that recruitment efforts are underway but there continue to be significant challenges in hiring due to the current workforce shortages. There are also some ongoing concerns regarding food quality and dietary services, and some environmental/ physical plant problems that are not fully resolved. OR's will continue to monitor for any further decline in regard to these and other components of overall resident care, exercise of rights, and quality of life.

Respectfully Submitted,

Joani F. Latimer, State Long-Term Care Ombudsman

4/8/2025
Date