OFFICE OF THE LONG-TERM CARE OMBUDSMAN

EST. WITHIN THE PA DEPARTMENT OF AGING

October 27, 2025

Eighth 60-Day Patient Care Ombudsman Report

Re: LaVie Care Centers, LLC
Case No. 24-55507-PMB

As directed by the court, and pursuant to 11 U.S.C. § 333(a)(2), Fed. R. Bankr. P. 2007.2(c), the following is my eighth 60-day report for the above-captioned case. Earlier bankruptcy reports had been sent on 9/5/24, 10/30/24, 12/31/24, 2/28/25, 4/30/25, 6/30/25, and 8/27/25.

Local ombudsmen have continued to conduct regular visits to these facilities. There are no resident concerns directly related to the bankruptcy proceedings.

The sale of these six (6) facilities to Avardis Health was completed on 6/1/25.

Pennknoll Village	Skilled-nursing facility	Bedford County
Locust Grove Retirement Village	Skilled-nursing facility	Juniata County
The Manor at St. Luke Village	Skilled-nursing facility	Luzerne County
The Pavilion at St. Luke Village	Skilled-nursing facility	Luzerne County
Luther Ridge at Seiders Hill	Assisted-living facility	Schuylkill County
The Manor at Penn Village	Skilled-nursing facility	Snyder County

General concern

1. On 10/14/25, a resident at **Pennknoll Village** contacted the local ombudsman with concerns about the admissions contract. The local ombudsman filed a formal complaint with the Department of Health on 10/21/25 and is awaiting to hear of any updates.

Regulatory concerns

1. Based on a Medicare and Medicaid Recertification, State Licensure, Civil Rights Compliance, and Abbreviated Complaint Survey completed on 9/12/25, it was determined that **The Pavilion at St. Luke Village** was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations. The facility failed to:

    - Provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by two residents out of the 22 residents [illegible]

reported by seven out of the 11 residents during a resident group interview.

- Maintain accurate and complete clinical records for one of 22 sampled residents.
- Provide nursing services consistent with professional standards of practice by failing to thoroughly assess, obtain physician orders, and develop and implement a person-centered comprehensive care plan in accordance with standards of practice, for one resident out of 22 sampled, and failed to provide person-centered care to meet the clinical needs by failing to monitor intravenous therapy (a way of giving medication or fluids through a needle or tube inserted into a vein) in accordance with professional standards of practice for one of 22 residents sampled.
- Put forth sufficient efforts to resolve continued resident complaints and grievances expressed during Resident Council meetings, including those voiced by seven of 11 residents attending a resident group meeting, and failed to keep the residents apprised of the status of the facility's decisions and efforts toward grievance resolution.
- Ensure the Minimum Data Set Assessments (MDS) accurately reflected the status of three residents out of 22 sampled.
- Ensure that a resident's comprehensive care plan was reviewed and revised as needed to accurately reflect the current needs and services required by one of 22 residents sampled.
- Provide care and services designed to prevent potential complications associated with enteral tube feedings for one resident receiving enteral nutrition out of 22 residents sampled.
- Develop and implement an individualized person-centered plan to render trauma-informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 22 residents reviewed.

The Patient Care Ombudsman and local ombudsman shall continue to monitor these concerns.

2. Based on an Abbreviated Survey in response to a Complaint Investigation and an Incident, completed on 9/11/25, it was determined that **The Manor at Penn Village** was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.

    - The facility failed to implement interventions to decrease the potential for resident elopements for one of four residents reviewed.

    The Patient Care Ombudsman and local ombudsman shall continue to monitor this concern.

Luther Ridge at Seiders Hill, which had been on a Department of Human Services provisional license, was re-issued a regular license on 8/28/25.

We trust that the information included in this report is satisfactory to the Court. We will continue to have the local ombudsman conduct site visits with the facilities which have not yet been sold and meet with residents to ensure their quality of care and life continue to be positive.

For additional information or should you have any questions, please do not hesitate to contact the PA Office of the Long-Term Care Ombudsman at (717) 783-7096.

Sincerely,

Margaret D Barajas

Margaret Barajas
State Long-Term Care Ombudsman