OFFICE OF THE LONG-TERM CARE OMBUDSMAN

EST. WITHIN THE PA DEPARTMENT OF AGING

April 1, 2026

First 60-Day Patient Care Ombudsman Report

Re: Whitehall Manor Inc. and
Saucon Manor, Inc.
Case No. 25-15241
(PMM)

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 first 60-day report for the above-captioned case.

Whitehall Manor Inc.

General Information

Whitehall Manor offers personal care services in Lehigh County, Pennsylvania, under a regular license by the PA Department of Human Services. The population they serve is primarily geriatric and offers a specialized secure dementia unit. It is not part of a continuing care retirement community.

The facility has a capacity of 130 beds, of which 114 were occupied as of 3/24/2026. This includes a 20-bed secure dementia care unit, of which 19 were occupied.

The current occupancy rates appear consistent from facility census reports over the last year.

Local ombudsman records indicate that this census, based on the number of available beds, is higher than other personal care facilities in the area.

Local ombudsmen conduct regular visits to the facility.

Environmental Observations

Whitehall Manor has a 20-bed secure dementia unit with coded doors. An up-to-date activities calendar is posted. Snacks are available for residents. The temperature is comfortable. However, the facility has an ongoing infestation of mice. Ombudsman witnessed mice feces on boxes and

cans in the food pantry. Some bags of food in plastic have been gnawed through by mice. On 3/16/2026 visit, ombudsman observed one dead mouse lying on the pantry floor. Pantry had strong odor of dead mice. Reported to newly appointed administrator, Jenn Atiyeh.

In a visit of 3/13/2026, the local ombudsman reported that call bells were not always answered promptly and staff do not wear visible name badges.

As of 2/19/2026, ombudsman observed temperatures log on refrigerator in secure dementia unit that has not been completed since November 2025. Upon opening the refrigerator, it contained nutritional supplement items in both freezer and refrigerator sections. Also noted that knobs are missing on the thermostats in the memory care unit.

Staffing/Operations

The Department of Human Services reports 155 daily staffing hours with 116 hours waking staff.

Complaints/Concerns

One (1) case has been instituted on behalf of residents since 11/4/2025.

Residents reported missing clothing.

Regulatory Issues/Department of Human Services

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing review on 11/06/2025, 11/10/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained. Plan of correction included:

- Record confidentiality
- FS Orientation 1st Day
- Staff training records
- Concerns with enabler bar not being covered
- Steam table was on and unattended in memory care unit
- Unlabeled and undated food in refrigerator/freezer
- Documentation of dietary change to mechanical soft not signed or dated
- Cigarette butts on ground in smoking area
- PRN cart unlocked, unattended and accessible to dinging room
- OTC medication did not have label with residents name
- Glucometer reading incorrectly recorded on resident record
- Missing strength of medication on the medication administration record
- Cognitive preadmission screening incomplete for secure dementia unite resident

- Missing assessment and support plans for two residents

No recent Civil Money Penalties have been levied against the facility.

Saucon Valley Manor I

General Information

Saucon Valley Manor I offers personal care services in Northampton County, Pennsylvania, under a provisional license issued by the PA Department of Human Services. The population they serve is primarily geriatric and offers a specialized secure dementia unit. It is not part of a continuing care retirement community.

The facility has a capacity of 201 beds, of which 191 beds were occupied as of 3/30/2026. This includes 100 bed secure dementia care beds. Ombudsman has an ongoing concern receiving proper census information during facility visits.

The current occupancy rates appear consistent from facility census reports over the last year.

Local ombudsman records indicate that this census, based on the number of available beds, is slightly higher than other personal care homes in the area.

Local ombudsmen conduct regular visits to the facility.

Environmental Observations

Saucon Valley Manor has three (3) secured dementia units. An up-to-date activities calendar and menu are posted. Residents report snacks are not offered. Staff do not wear name badges consistently. Ombudsman notes ongoing concerns regarding kitchen area and 2nd floor ceiling leak.

In a visit of 3/30/2026, the local ombudsman reported kitchen overall filthy noting case of strawberries in produce cooler covered in mold.

On initial visit 2/19/2026, regional ombudsman noted kitchen area in need of a deep clean. Pre-wrapped plates of food sitting in various spots of kitchen. Unidentifiable food/substances were observed in a bowl. Dietary manager shared that the facility prepares meals for Saucon II and III (buildings share same property).

In a visit on 3/30/2026, resident raised concern that CO2 for the soda machine are not being delivered so they cannot have soda. Kitchen staff stated that he is aware of the issue and stated they order them weekly, but it has not arrived yet.

Ombudsman noted ceiling leak on 2nd floor during initial 2/19/2026 visit. Administrator reported that residents do not use that room, however there were several residents participating in an activity in the area during the visit.

2nd Floor ceiling leak and buckets

Photo taken during 2/26/2026 visit located in front of resident room

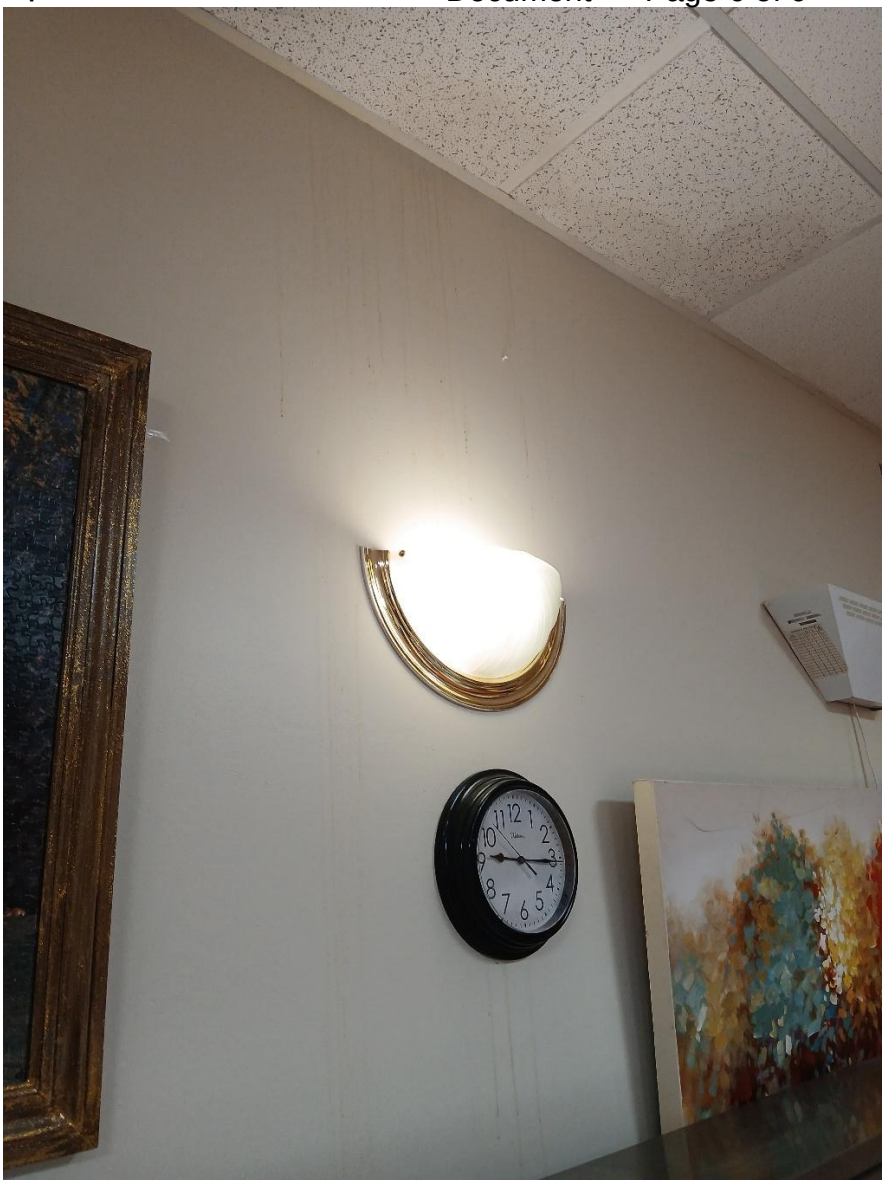

Photo taken 3/23/2026 2nd floor, water running down wall in hall

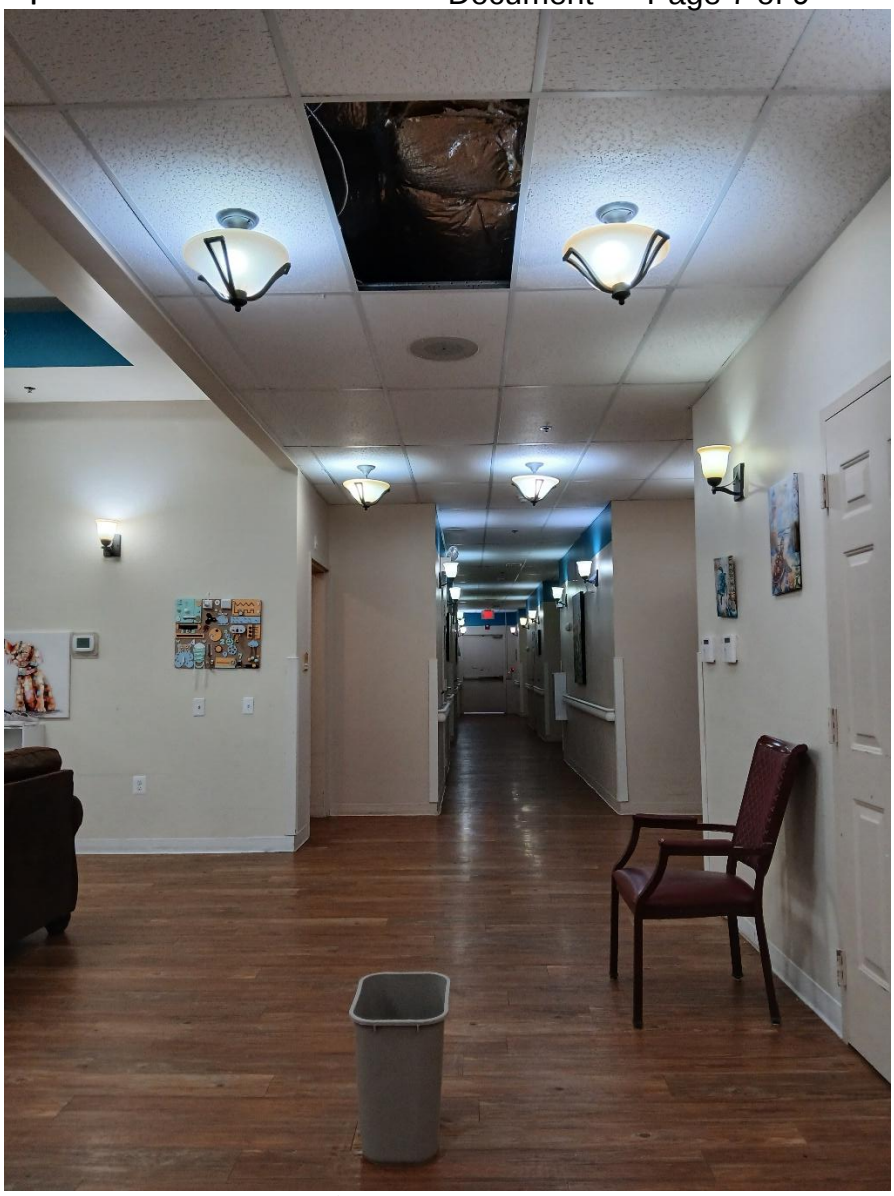

Photo taken 3/23/2026 2nd floor memory unit, heating coil leak

In a visit on 3/18/2026, ombudsman was told that the heating coil hydraulic coil must be fabricated in updated New York as it is twelve (12) years old.

Ombudsman notes during initial visit on 2/19/2026 in stairwell B all three doors to each unit were propped open by fire extinguishers. Ombudsman asked Maintenance why this was being done. He stated in the wintertime he does this to prevent the fire water line from freezing. This was brought up to administrator upon exiting facility.

Staffing/Operations

The Department of Human Services reports 300 daily staffing hours with 225 hours waking staff.

Complaints/Concerns

Two (2) cases have been instituted on behalf of residents since 12/1/24.

On an ombudsman visit of 1/10/25, a resident reported that the food is sometimes cold, and they go without eating because of the food temperature.

Regulatory Issues/Department of Human Services

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's licensing inspections on December 3, 2025; December 4, 2025; February 4, 2026 of the above facility, the violations specified were found.

Based on violations with 55 Pa. Code Ch. 26000 (relating to Personal Care Homes), the Department hereby REVOKES certificate of compliance (LICENSE NO 205810) dated September 3, 2025 to September 3, 2026 and issues a FIRST PROVISIONAL license to operate the above facility. The FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified. Your FIRST PROVISIONAL license is valid from MARCH 27, 2026 to SEPTEMBER 27, 2026.

Description of violations:

- Residents' enabler bars were not securely attached to bed frame\
- Locking of poisonous materials
- Wi-Fi router installed on wall missing the cover and had motherboard exposed with battery pack hanging from the unit
- Snow covering sidewalks and paths
- Unlabeled, undated food items in refrigerator and freezer
- Standing freezer in main kitchen temperature was 28 degrees Fahrenheit
- Fire extinguisher in dementia unit missing the tag
- Approximately four (4) inches of snow blocking exit
- Medical evaluations for residents incomplete
- Medication mislabeled as PRN instead of standing order
- Rasp assessment not completed annually
- Medications discontinued remained in medication cart
- Missing directions to operate locking mechanism Floor D dementia unit elevator

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We trust that the information included in this report is satisfactory to the Court. We will continue to have the local ombudsman conduct weekly 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 Barajas
State Long-Term Care Ombudsman