Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

April 18, 2025

[redacted], ASSISTANT SECRETARY
EMERITUS CORPORATION
[redacted]

RE: BROOKDALE LATROBE
500 BROUWERS DRIVE
LATROBE, PA, 15650
LICENSE/COC#: 42853

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/06/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BROOKDALE LATROBE* **License #**: *42853* **License Expiration**: *02/05/2026*

Address: *500 BROUWERS DRIVE, LATROBE, PA 15650*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *EMERITUS CORPORATION*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/28/2001* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Incident* **Exit Conference Date**: *02/12/2025*

Inspection Dates and Department Representative

02/06/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *60*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *40* **Residents Served**: *23*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *60*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

02/06/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/17/2025*

03/28/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/04/2025*

Inspections / Reviews *(continued)*

04/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/14/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/17/2025*

04/18/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/14/2025*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident #1 was admitted to the home on [redacted] with the assistance of two staff persons for all care needs due to behaviors which included hitting and kicking. On 11/4/24, resident #1's doctor indicated that the resident had been more combative with severe psychosis and aggressive behaviors. On 12/11/24 resident #1 had a physical altercation with resident #2. Both residents were observed slapping and hitting each other in the dining room of the home. On 1/9/25, resident #1's mental health professional indicated that the resident had been "more anxious, busy, difficult to redirect, has poor social boundaries and stands on the feet of other (residents) resulting in altercations. Needs 1:1." On 2/1/25, resident #1 had a physical altercation with resident #3. Both residents punched each other with closed fists. On 2/5/25, resident #1 was standing very closely behind resident #4 in the dining room. When resident #4 turned around, [redacted] elbowed resident #1 in the chest.
During the on-site investigation, agents of the Department requested clarification of the mental health professional's letter dated 1/9/25 of "Need 1:1" as the home was unsure of the order. The mental health professional indicated that resident #1 "has a diagnosis of dementia with behavioral disturbance. (The resident had been) more anxious, busy, and getting into altercations with others resulting in the need of one-on-one de-escalation during those times." The home has repeatedly permitted resident #1 to get within close physical proximity to other residents with [redacted] aggravated aggressive behaviors leading to the undignified behavior of resident #1 and treatment of other residents of the home.

Repeat Violation: 11/28/23 et al.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Plan of Correction Brookdale Latrobe. The following is the Plan of Correction for Brookdale Latrobe regarding the Statement of Deficiency dated February 6, 2025 for the annual survey. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.
2600.42.c A resident shall be treated with dignity and respect
2/17/2025- Retraining was initiated by the Executive Director (ED), Health & Wellness Director (HWD) and Business office Manager (BOM) to appropriate clinical staff, management staff and residents regarding the community policy on treating the residents with dignity and respect as documented in the Resident Rights. Documentation of the staff and resident education shall be kept in accordance with 2600.65i.
2/17/2025- Current residents and staff have signed/dated the residents right upon admission/hire and will continue to review resident right during resident counsel and all staff meetings.
Ongoing - The ED, HWD and management team will continue to promote resident dignity at orientation, dementia training, annual trainings, during staff meetings and whenever indicated.
Ongoing- To assist with compliance, the ED or designee will review any potential incidents as they occur for one month starting immediately and will verify current residents understand, to their ability, their rights.

42c - Treatment of Residents (continued)

Ongoing- The administrator or designee shall interview at least 3 residents per week for 2 weeks then monthly thereafter, in private, to verify resident rights are protected and that residents are treated with dignity and respect. Documentation of the interviews shall be kept for 2 months.
Ongoing- Monthly reviews will then be completed thereafter by the ED or designee to verify compliance and to determine if any further action is warranted starting immediately.
Supporting Documentation: record of staff training, Resident Rights.

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented ([redacted] - 04/18/2025)

85a - Sanitary Conditions

2. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At 11:30 a.m., there were no paper towels, mechanical air blower, individual cloth towels or other sanitary means of hand drying in the common bathroom of the secure dementia care unit (SDCU).

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2/6/2025- Maintenance Coordinator immediately installed a paper towel and soap dispenser in the common bathroom of the Secured Dementia Care Unit (SDCU) Inspector verified installation during site visit.
2/17/2025- ED retrained the maintenance personal regarding the Sanitary Conditions to verify current residents/guest(s) have access to paper towels and soap in bathrooms.
Ongoing - Maintenance staff or designee will complete an audit of each bathroom to verify there are towels and soap available for use weekly for 4 weeks and monthly for 2 months thereafter.

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented ([redacted] - 04/18/2025)

85d - Trash Receptacles

3. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d - Trash Receptacles *(continued)*

Description of Violation

At approximately 12:30 p.m. there was a half-full, uncovered, unattended trash can in the bathroom next to the medication room.

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The trash can next to the medication room bathroom DID have a cover with a "hole" to place garbage in, this was approved previously during an inspection.
2/17/2025- The ED retrained staff, including maintenance and housekeeping of the policy to verify garbage cans have a covered lid in common areas and bathrooms.
2/27/25- Maintenance and housekeeping did a complete audit of all the garbage cans in the community The ED then immediately placed an order for new garbage cans that the inspector approved during the visit. The garbage cans that the inspector on 2/6/25 did not approve were replaced upon delivery of the new ones.
Ongoing- the housekeeping and maintenance staff will complete weekly audits to verify the garbage cans have covered lids for 2 months and then monthly after for 2 months. Documentation can be provided of the audits.

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented ([redacted] - 04/18/2025)

89b - Hot Water Temperature

4. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At 10:45 a.m., the hot water temperature at the common men's bathroom sink measured 123.8 degrees Fahrenheit.

At 10:46 a.m., the hot water temperature at the common women's bathroom sink measured 124.6 degrees Fahrenheit.

At 10:50 a.m., the hot water temperature at the bathroom sink in the SDCU measured 125.8 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 03/28/2025)***

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89b - Hot Water Temperature (continued)

remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.
2/17/2025- ED retrained maintenance Manager of the water temp policy to verify temperatures are not above 120 degrees Fahrenheit in common areas. Maintenance immediately turned the faulty tank off. A new tank was on ordered previously and installed the week of 2/17/25. Upon installation, hot water temperatures were regulated between 113-115 degrees Fahrenheit. Continued monitoring of water temperature were completed daily of 50% of the affected area and for 1 additional week to verify compliance.
Ongoing- Maintenance will continue to monitor weekly indefinitely to verify temperatures do not go above 120 degrees and document into the TELS system.

Licensee's Proposed Overall Completion Date: *03/17/2025*

Implemented ([redacted] - 04/18/2025)

92 - Windows

5. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

There were multiple operable windows of the home that did not have window screens.
In addition, the window screens in the windows of resident bedrooms 36, 37, 38, & 57 were not seated correctly, which created a gap greater than 2 inches at the top and bottom of the window screen.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

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2/17/2025-ED retrained the Maintenance and Housekeeping departments to verify all window screens are intact, in good repair and are secure on 2/17/25. Housekeeping and Maintenance completed a complete building audit of the window screens. The maintenance manager ordered new screens and will install upon delivery.
Ongoing- maintenance and housekeeping will complete weekly audits for 2 months to verify all window screens are in compliance and will order and replace new screens as necessary. They will continue to audit monthly for 2 more months thereafter.

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented ([redacted] - 04/18/2025)

102i - Soap Dispenser

7. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

At 11:30 a.m., there was no soap in the common bathroom of the SDCU.

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This was addressed in accordance to 2600.85a and 2600.102.f. Maintenance Coordinator immediately installed a paper towel and soap dispenser in the common bathroom of the SDCU. Inspector verified installation during site visit.
2/17/2025- ED retrained the maintenance personal regarding the Sanitary Conditions to verify current residents/guest have access to paper towels and soap in bathrooms. Maintenance staff or designee will complete an audit of each bathroom to verify there are towels and soap available for use weekly for 4 weeks and monthly for 2 months thereafter

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented (- 04/18/2025)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 11:09 a.m., the freezer in the kitchenette of the SDCU was 10 degrees Fahrenheit and at 2:00 p.m., it was 2 degrees Fahrenheit.

Plan of Correction ***Accept (- 03/28/2025)***

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I am asking for this to be removed -During the inspection, it was found that the thermometer was not reading the proper temperature and found that the thermometer was faulty. Immediately the maintenance director contacted

103f - Refrigerator/Freezer Temps (continued)

the HVAC vendor. Upon arrival at 2:30PM 2/6/25 the HVAC tech. found the freezer temperature was -1 degree f. A new temperature gauge was replaced and a new digital temperature display with remote sensor in the box for more accurate display readings was installed 2/13/25. It was noted that the temperature was never below policy standard.
2/17/2025-The ED retrained maintenance, dining staff on proper temperature reading policies for coolers and freezers.
Ongoing- dining staff or designee will take daily temperature readings to verify compliance.
Documents: HVAC Vendor's work order.

Licensee's Proposed Overall Completion Date: *03/17/2025*

Implemented (- 04/18/2025)

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #5 was prescribed Metformin HCL 500mg, give by mouth twice daily; however, the pharmacy label indicated give once daily.

Resident #6 was prescribed Tylenol 325mg, give two tablets twice daily; however, the pharmacy label indicated give 4 times per day as needed.

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2/6/2025- Resident #5- Immediately a "Direction Change Refer to MAR" label was placed on the medication.
Resident #6- Asking to be removed: There are 2 orders for Tylenol 325 mg (1 straight order and 1 PRN order on 2 separate cards) Labels and MAR are correct per the dosage. Inspector signed off as "OK" on the MAR during the audit.
3/10/20205-HWD retrained nursing staff and medication technicians on resident medication labeling.
2/28/2025- HWD did a complete med cart audit of med carts to verify all ordered medications are in compliance.

184a - Resident's Meds Labeled (continued)

Ongoing- HWD or designee will continue to do weekly audits for 2 months, then monthly after.
Documentations: labels and inspector "ok" of MAR regarding resident #6

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented ([redacted] - 04/18/2025)

187a - Medication Record

12. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #4 had a CPAP machine on the February 2025 medication administration record (MAR). The home's staff were initialing the MAR to indicate they were assisting the resident with the CPAP at bedtime; however, the CPAP has not been in the home for several months.

Resident #5 was prescribed Tobramycin / Dexamethasone Ophthalmic Suspension 0.3%-0.1%, place one drop in the left eye four times per day for pain. On 2/3/25 at 7:00 a.m., 2/4/25 at 6:00 a.m. & 7:00 p.m., and 2/5/25 at 7:00 p.m., multiple staff initialed the February 2025 MAR as administering the medication; however, the medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

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2/6/2025- Resident #4 order for CPAP was immediately from MAR. The Support Plan for resident #4 dated 12/15/24 stated that the CPAP was Discontinued and no longer in use.

187a - Medication Record (continued)

2/11/2025- HWD retrained the HWC and Med-tech staff on signing-off of medications that were not in-house per community policy.
2/24/2025- HWD completed full Med Cart audits to verify all ordered medications and equipment are in house and documented properly per community policy.
Ongoing- HWD or designee will continue to do weekly audits for 2 months, then monthly after.

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented ([redacted] - 04/18/2025)

187d - Follow Prescriber's Orders

13. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #5 was prescribed Tobramycin / Dexamethasone Ophthalmic Suspension 0.3%-0.1%, place one drop in the left eye four times per day for pain. However, this medication was not administered to the resident on 2/3/25, 2/4/25, & 2/5/25 because the medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

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2/11/2025- HWD retrained the HWC and Med-tech on signing-off of medications that were not in-house.
2/24/2025-HWD completed full Med Cart audits to verify all medications are in house and documented properly.
Ongoing- HWD or designee will continue to do weekly audits for 2 months, then monthly after.

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented ([redacted] - 04/18/2025)

233c - Key-Locking Devices

14. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism were not conspicuously posted near the door closest to the dining room in the SDCU.

233c - Key-Locking Devices *(continued)*

Plan of Correction ***Accept (- 03/28/2025)***

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I am asking for this to be removed. The attached is the posting that was at the door and noted within the picture the code to exit. The inspector stated was unable to see the code and when it was pointed out was able to see it. Since the report, a new code was placed that is lighter and larger.
Documentation: Proof of original code that was present at the exit door in question.

Licensee's Proposed Overall Completion Date: *03/17/2025*

Implemented (- 04/18/2025)

234d - Support Plan Revision

15. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for resident #1 was completed on ; however, the plan was not updated to include the behavior/cognitive needs for the resident in the areas of irritability, judgment, agitation, and aggression.

Plan of Correction ***Accept (- 03/28/2025)***

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3-3-2025- HWD updated the Care Plan/RASP to indicate the updates of behaviors/cognitive needs.
2-17-2025- ED retrained the HWD on timely updating any condition changes to residents on the RASP.
Ongoing- ED or designee to audit resident files to verify all updates are included and timely. HWD or designee to audit records weekly for 1 month and monthly thereafter to verify updates are captured.
Documentation: updated Care Plan/RASP

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented (- 04/18/2025)