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

October 6, 2025

[REDACTED] PRESIDENT
THE FOUNTAINS AT LATROBE LUXURY SENIOR CARE LLC
PO BOX 607
INDIANA, PA, 15701

RE: THE FOUNTAINS AT LATROBE LUXURY SENIOR CARE LLC
317 STARLIGHT COURT
LATROBE, PA, 15650
LICENSE/COC#: 45657

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/08/2025 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: *THE FOUNTAINS AT LATROBE LUXURY SENIOR CARE LLC* **License #**: *45657* **License Expiration**: *04/02/2026*

Address: *317 STARLIGHT COURT, LATROBE, PA 15650*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *THE FOUNTAINS AT LATROBE LUXURY SENIOR CARE LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *03/05/2025* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *12* **Waking Staff**: *9*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/08/2025*

Inspection Dates and Department Representative

08/08/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *12*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *12*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

08/08/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/29/2025*

Inspections / Reviews *(continued)*

09/02/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *10/02/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *09/09/2025*

09/05/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *10/02/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *10/03/2025*

10/06/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *10/02/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

65d - Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, date of hire [redacted] provides unsupervised ADL services. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept ([redacted] - 09/05/2025)***

On 8/25/25, facility administrator, [redacted] personally reviewed all of the staff files for The Fountains at Latrobe to ensure compliance with state guidelines/regulations for staff working in Personal Care Homes. No holes in review were identified.

Staff person A provided a copy of [redacted] DCST certificate to facility administrator on 8/11/25.

All new facility hires will have a checklist for their employee file. New staff will not be permitted to work on the floor until all required documentation is complete. Facility administrator/designee will review all new staff files on a monthly basis for the next 3 months.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented ([redacted] - 10/06/2025)

65g - Annual Training Content

2. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff person B, date of hire [redacted], did not receive orientation training during the training year January 2024 to December 2024.

Plan of Correction ***Accept ([redacted] - 09/05/2025)***

On 8/25/25, facility administrator, [redacted] personally reviewed all of the staff files for The Fountains at Latrobe to ensure compliance with state guidelines/regulations for staff working in Personal Care Homes. No holes in review were identified.
All new facility hires will have a checklist for their employee file. New staff will not be permitted to work on the floor until all required documentation is complete. Facility administrator/designee will review all new staff files on a monthly basis for the next 3 months. Staff person B received orientation training on 8/11/25.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented ([redacted] - 10/06/2025)

81b - Resident Personal Equipment

3. Requirements

81b - Resident Personal Equipment *(continued)*

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

At approximately 11:00 a.m., the bedside enabler on the right side of resident #1's bed was improperly secured allowing for approximately 5 inches of movement to the left and to the right from its center (resting position) allowing for an aggregate range of motion of approximately 10 inches.

Plan of Correction ***Accept (- 09/05/2025)***

The enabler was secured to the bedframe on 8/11/25 by facility maintenance/designee, It was reviewed for sturdiness by facility administrator,
Upon admission, residents will be evaluated for use of an enabler and the results of the evaluation will be included in said residents' RASP.
All facility enablers will be reviewed monthly for the next 3 months by facility administrator/designee.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

82c - Locking Poisonous Materials

4. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At approximately 9:15 a.m., there were several brown plastic bottles of Peroxide located in the home's medication closet with a manufacturer's label indicating "keep on the reach of children, if swallowed get medical help or contact poison control center". The bottles of Peroxide were unlocked unsecured, unattended, and accessible to residents. However, not all residents of the home to include resident #2, have been assessed capable of recognizing and using poisons safely.

At approximately 10:15 a.m., there was an aerosol can of Lysol Disinfectant in the common bathroom immediately next to the home's medication room. with a manufacturer's label indicating "call police and poison control if swallowed" The aerosol can of Lysol Disinfectant was unlocked unsecured, unattended, and accessible to residents. However, not all residents of the home to include resident #2, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 09/05/2025)***

The poisonous subject in question was removed at the time of inspection and placed under secure lock by facility administrator on 8/8/25. On 8/11/25, an audit of the entire facility was completed and no poisonous substances were found to be unlocked or unsecured. Going forward, facility night shift staff will ensure compliance with the regulation 2600.82C and facility night shift checklist was updated to include monitoring for poisonous substances.
On 8/18/25, facility administrator, provided education regarding the requirements of keeping poisonous materials locked and secured appropriately. In addition to this, it has been added onto the nightshift checklist to ensure that no potentially poisonous cleaning materials are left out unattended.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

121a - Unobstructed Egress

5. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At approximately 11:10 a.m., the exit located immediately next to resident room #260 and #265 was manually locked and unable to be opened, staff, residents, and visitors did not have immediate access to the lock's key and were unable to immediately access the exit.

At approximately 11:45 a.m., exit D did not have a sign indicating that its magnetic locking mechanism was on 15 second delay nor was the code posted to operate the magnetic lock posted at the exit.

Plan of Correction ***Accept (- 09/05/2025)***

On 8/11/25, Facility Maintenance, , took the exit sign near facility rooms 260 and 265 out of commission. Facility fire exit map was updated to reflect the change and distributed throughout the facility. Updated map was also provided to local fire department to fire chief,

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

132c - Fire Drill Records

6. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill log for the fire drill conducted on 4/16/25, did not indicate the number of seconds for the evacuation time.

The fire drill log for the fire drill conducted on 5/21/25, did not indicate the number of seconds for the evacuation time.

The fire drill log for the fire drill conducted on 6/17/25, did not indicate the number of seconds for the evacuation time.

Plan of Correction ***Accept (- 09/05/2025)***

Going forward, facility will ensure that all fire drills are conducted under the safe evacuation time and if the evacuation time goes over the safe evacuation time frame provided by fire expert, facility administrator/designee will then contact to do a follow-up evaluation of evacuation of the facility. Going forward, facility administrator, will ensure that all facility fire drills are measured down to the seconds.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

132d - Evacuation

7. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The most recent annual fire drill evacuation observed by a fire safety expert was conducted on 7/15/25, and indicated a safe evacuation time of 11 minutes and 59 seconds. However, the fire drill conducted on 4/16/25, had an evacuation time of 13 minutes and the fire drill conducted on 6/17/25, had an evacuation time of 12 minutes.

Plan of Correction ***Accept (- 09/05/2025)***

Going forward, facility will ensure that all fire drills are conducted under the safe evacuation time and if the evacuation time goes over the safe evacuation time frame provided by fire expert, facility administrator/designee will then contact to do a follow-up evaluation of evacuation of the facility. Going forward, facility administrator, will ensure that all facility fire drills are measured down to the seconds.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

141a 1-10 Medical Evaluation Information

8. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's most recent Documented Medical Evaluation completed on did not include an assessment of the resident's ability to self-administer medication. The field was blank.

Resident #2's most recent Documented Medical Evaluation completed on indicated the resident was appropriate for secured dementia care only.

Resident #3's most recent Documented Medical Evaluation completed on did not indicate a diagnosis of Dementia.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction ***Accept (- 09/05/2025)***

On 8/11/25, a new medical evaluation was performed for Resident #1, Resident #2, Resident #3, and Resident #6 with all items in question being correct on the new evaluation forms. Facility administrator, completed the new evaluations for these residents.
Going forward, facility administrator, will audit all resident DMEs to ensure completeness and accuracy. Audits will occur when DMEs obtained from facility clinical resources.
Resident #3 has not been diagnosed with dementia by a licensed medical professional.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

181c - Self-administration Assessment

9. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #3's most recent Documented Medical Evaluation completed on indicated was not assessed to self-administer medication. However, at approximately 10:30 a.m., there was a bottle Top Care Allergy Relief Nasal Spray on the bathroom sink located in the resident #3's private bathroom.

Plan of Correction ***Accept (- 09/05/2025)***

Resident #3 received a new DME on 8/11/25 that included for the ability to self-administer medications. Facility staff have been educated on regulation pertaining to self administration on 8/18/25 by facility administrator/designee.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

183e - Storing Medications

11. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #5, was prescribed Insulin Lispro 100/ml Pen – Inject units subcutaneously per sliding scale before meals and at bedtime: 0-60 + give glucose or glucose substitute and recheck; 61-200 = 0; 201-250 = 2; 251-300 = 4; 301-350 = 6; 351-400 = 8; 401-450 = 10; Greater than 450 = 10 recheck in 2 hours. However, the prescribed Insulin Lispro 100/ml Pen did not have an open date documented on it.

Plan of Correction ***Accept (- 09/05/2025)***

Regarding Resident #5, Lispro Insulin Pen was discarded at time of inspection. Resident had other unopened pens inside of facility med room refrigerator. A new one was opened and dated appropriately by facility administrator, All Med Trained Staff have been educated on the importance of marking an open date on medications that require a date by facility administrator, on 8/18/25.

183e - Storing Medications *(continued)*

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

185a - Implement Storage Procedures

12. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #5 was prescribed Insulin Lispro 100/ml Pen – Inject units subcutaneously per sliding scale before meals and at bedtime: 0-60 + Give glucose or glucose substitute and recheck; 61-200 = 0; 201-250 = 2; 251-300 = 4; 301-350 = 6; 351-400 = 8; 401-450 =10; Greater than 450 = 10 recheck in 2 hours. On 8/7/25, at 8:30 p.m., the resident's blood glucose monitor indicated a blood glucose reading of 410. However, the blood glucose measurement was not indicated on the resident's August 2025, Medication Administration Record.

Resident #6 was ordered blood glucose checks daily and as needed. The resident's blood glucometer indicated a reading of 258 on August 7, and 252 on August 6. However, the blood glucose readings were not indicated on the resident's August 2025 Medication Administration Record.

Plan of Correction ***Accept (- 09/05/2025)***

At the time of inspection, there was nowhere to document in the MAR the blood sugar readings. Facility administrator, then reached out to Pharmacy on 8/11/25, and they added a place in the MAR for facility staff to document all required blood sugar readings per MD orders.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented (- 10/06/2025)

225a - Assessment 15 Days

14. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3 initial assessment does not include how the resident's needs related to diagnose/s are to be met.

Resident #4 Resident Assessment dated 4/2/25, did not include the resident's use of an enabler bar.

Resident #6 most recent Resident Assessment completed on did not indicate the date the assessment was finalized.

Plan of Correction ***Accept (- 09/05/2025)***

In regards to Resident Assessments: Resident #3 Assessment has been updated to reflect how needs will be met in regards to Hypertesnion diagnosis. This update was completed on 8/11/25 by facility administrator, and reviewed by facility medical director/designee on 8/11/25.

Resident #4 Assessment has been updated to show the use of an enabler bar. This update was completed on

225a - Assessment 15 Days (continued)

8/11/25 by facility administrator, [REDACTED] and reviewed by facility medical director/designee on 8/11/25.

Resident #6 Assessment has been updated to show finalized date of Assessment. This update was completed on 8/11/25 by facility administrator, [REDACTED] and reviewed by facility medical director/designee on 8/11/25.

Going forward, facility administrator [REDACTED] designee will verify that all pertinent information is included in every resident Assessment.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented ([REDACTED] - 10/06/2025)

227a - Support Plan 30 Days

15. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #3's initial Resident Support Plan did not indicate a date of completion.

Resident #4 initial Support Plan completed on [REDACTED], indicated the resident could transfer in/out of bed independently. However, the resident required the utilization of a bed side enabler to assist during transfers to/from bed.

Resident #6's most recent Resident Support Plan did not indicate the date the support plan was finalized

Plan of Correction ***Accept ([REDACTED] - 09/05/2025)***

In regards to RASPs:
Resident #3 RASP has updated to include date of completion. This update was completed on 8/11/25 by facility administrator, [REDACTED]
Resident #4 RASP has been updated to include the use of a bedside enabler bar. This update was completed on 8/11/25 by facility administrator, [REDACTED]
Resident #6 RASP was updated with the date of completion. This update was completed on 8/11/25 by facility administrator, [REDACTED]

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented ([REDACTED] - 10/06/2025)