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

April 20, 2026

[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 02/05/2026 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**: *02/05/2027*

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**: *06/08/2021* **Issued By**: *D&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *79* **Waking Staff**: *59*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *02/05/2026*

Inspection Dates and Department Representative

02/05/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *56*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Claire Bridge* **Capacity**: *40* **Residents Served**: *22*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *55*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *23*

Have Physical Disability: *0*

Inspections / Reviews

02/05/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/28/2026*

03/10/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/15/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/27/2026*

Inspections / Reviews *(continued)*

04/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/15/2026*

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

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 1/31/26, from 11:00 p.m. to 7:00 a.m., there were 54 residents in the home; however, there were no staff on duty who were certified in CPR/1st aid.

On 2/1/26, from 11:00 p.m. to 7:00 a.m., here were 54 residents in the home; however, there were no staff on duty who were certified in CPR/1st aid.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

The schedule was reviewed by the Executive Director and the Health and Wellness Director on 2/5/26 to verify compliance per state regulation, with at least 2 staff that are certified in CPR/First aid on each shift. The census in the community was 54 residents at time of audit.
The Executive Director re-educated the clinical management team on requirements for staffing with certified CPR and First aide associates. A CPR/first aid class was held at the community on 2/17/2026. Staff that needed certified were included in the classes. Sign in sheets attached. The staff scheduler and /or Executive Director will verify CPR/ 1sr Aid certification status when preparing the schedule. A tracking log with expiration dates has been created to verify certifications remain current by the business office manager.
The Executive Director / Health and Wellness Director or designee will audit CPR/first aid compliance monthly for the next 3 months to verify enough staff are CPR/First Aide certified, according to the regulation and census.

Licensee's Proposed Overall Completion Date: *03/09/2026*

Implemented ([redacted] - 04/20/2026)

82a - Poisonous Materials

2. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

The main janitorial electric closet housekeeping room had an unlabeled clear plastic spray bottle 1/3 full of clear liquid. There is no labeling on the spray bottle.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

Immediately the unidentified spray bottle found on 2/5/26 was discarded at the time of the survey by the Maintenance Director. All other spray bottles and chemical containers were checked to verify proper labeling per regulation.
The Executive Director re-educated the Maintenance Director on 2/5/26 on state regulation -poisonous materials and proper labeling of spray bottles. The Maintenance Director held an in-service with staff to review regulation 82a proper labeling of spray bottles on 2/10/26. Attached is the agenda, protocol and training sheet.
Ongoing compliance – starting 3/9- Audits will be completed monthly by the maintenance director or designee on all spray bottles by department supervisors and protocol will be reviewed annually or as safety regulations and operational needs change. Any unlabeled containers will be removed immediately and staff will be re-educated as needed.

82a - Poisonous Materials (continued)

Licensee's Proposed Overall Completion Date: *03/09/2026*

Implemented ([redacted] - 04/20/2026)

100b - Removal Snow/Obstructions

4. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

At 12:26 p.m., exit #71 there was approximately 2 to 3 inches of snow on the evacuation route leading away from the exterior of the exit door.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

Immediately on 2/5/26 the snow was removed at the time of survey from exit #71 by the Executive Director and the Maintenance Director– see attached photo.
The Executive Director re-educated maintenance and staff on the requirement to maintain all exits and walkways free from snow, ice or any obstructions to ensure safe emergency egress for residents and staff. The staff were instructed to notify the Executive Director / Manager on Duty immediately if an obstruction is observed. The snow removal company, T.L.Smith Enterprises, was contacted on 2/5/26 to remind them that part of their contract is to remove all obstructions from all exit doors at the community. All exits must be accessible at all times.
Ongoing compliance- starting week of 3/9- The Maintenance Director or designee will audit weekly x 1 month and then monthly to verify all egresses are free of obstruction including snow and ice.

Licensee's Proposed Overall Completion Date: *03/09/2026*

Implemented ([redacted] - 04/20/2026)

121a - Unobstructed Egress

7. 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

On 2/5/26, at 12:07 p.m., there was no signage for the magnetic locking systems delayed release mechanism on the point of egress leading from the rear of Wimmer Way hallway to the #8 dayroom's exit.

At 12:09 p.m., the exit directly across the hall from the copying room was unable to be completely opened. The door was unable to be opened due to excessive snow on the exterior side of the exit.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

Immediately on 2/5/26 the snow was removed at the time of survey from exit #71 by the Executive Director and the Maintenance Director– see attached photo.
The Executive Director educated maintenance and staff on the requirement to maintain all exits and walkways free from snow, ice or any obstructions to ensure safe emergency egress for residents and staff. The staff were instructed

121a Unobstructed Egress (continued)

to notify the Executive Director / Manager on Duty immediately if an obstruction is observed. The snow removal company, [redacted], was contacted on 2/5/26 to remind them that part of their contract is to remove all obstructions from all exit doors at the community. All exits must be accessible at all times.
Ongoing compliance starting week of 3/9 The Maintenance Director or designee will audit weekly x 1 month and then monthly to verify all egresses are free of obstruction including snow and ice.
The description of violation "on 2/5/26, at 12:07 p.m., there was no signage for the magnetic locking systems delayed release mechanism on the point of egress leading from the rear of Wimmer Way hallway to the #8 dayroom's exit. " Email sent to inspector on 3/4/26 and at the time of this POC, had not received a reply. The signage for the door was in place and the door was not obstructed.

Licensee's Proposed Overall Completion Date: *03/09/2026*

Implemented ([redacted] - 04/20/2026)

133.2 - Exit Signs Direction

8. Requirements

2600.
133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

At approximately 11:45 a.m., the Wimmer Way hallway, did not have a direct visual line to the nearest exit. However, there were no signs marking the line of travel to the exit located immediately outside of the point off egress at the left rear of Wimmer Way Hallway in Dayroom #8. The home served 56 residents.

At approximately 11:45 a.m., The Laurel Lane hallway did not have a direct visual line to the nearest exit. However, there were no signs marking the line of travel to the exit positioned directly behind the Laurel Lane hallway's rear door leading to the exit located in the home's secured unit. The home served 56 residents.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On February 6, 2026 the Executive Director retrained the Maintenance Director and staff on the requirements for exit sign usage. The training included a tour of the community and standing in various areas ensuring an exit sign was visible. The staff were also educated on the importance of maintaining clearly marked exits to ensure resident safety and proper emergency evacuation procedures.
The Maintenance Director or designee will tour (audit) the community to audit exit sign placement monthly for the next 3 months. The tour (audits) will then occur every 6 months.

Licensee's Proposed Overall Completion Date: *03/09/2026*

Implemented ([redacted] - 04/20/2026)

181e - Capable to Self Administer

9. Requirements

2600.
181.e. To be considered capable to self-administer medications, a resident shall:

181e - Capable to Self Administer *(continued)*

Description of Violation

At 12:20 p.m., there was a tube of Neosporin on the back of the commode located in the semi-private bathroom of resident [redacted]. However, the resident's most recent Resident Assessment and Support Plan completed on 3/24/25, indicated the resident had not been assessed to self-administer mediations.

At 12:20 p.m., there was a container of Desenex on the dresser located in resident [redacted] semi-private resident room. However, the resident's most recent Resident Assessment and Support Plan completed on 3/24/25, indicated the resident had not been assessed to self-administer mediations.

At 12:05 p.m., there was a partially used container of vapor rub on the resident's counter located in the [redacted] resident room. However, the resident's most recent Resident Assessment and Support Plan completed on 11/30/25, indicated the resident had not been assessed to self-administer mediations.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

Immediately on 2/5/26 the medications found in non self-administering residents rooms were removed by the Health and Wellness Director.
The Health and Wellness Director held an in-service on 3/4/26 with staff to review self- administering medication protocols, state regulation and community policy. The in-service included the requirement that medications must be secured and administered by staff unless a resident has documentation for self- administration.
On 3/4/26 an audit was conducted by the clinical staff to verify residents who are unable to self-administer medication had no medications in their rooms.
The Health and Wellness Director or designee will conduct room audits weekly for 4 weeks and then bi-weekly for 2 weeks to verify medications are not unsecured in resident rooms who are not self adminstering. Random audits monthly for 6 months.

Licensee's Proposed Overall Completion Date: *03/09/2026*

Implemented ([redacted] - 04/20/2026)

185a - Implement Storage Procedures

10. 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

At 12:20 p.m., there was a tube of Neosporin on the back of the commode located in the semi-private bathroom of resident [redacted]. The medication was unattended and unsecured.

At 12:20 p.m., there was a container of Desenex on the dresser located in resident [redacted] semi-private resident room. The medication was unattended and unsecured.

At 12:05 p.m., there was a partially used container of vapor rub on the resident's counter located in resident [redacted]

185a - Implement Storage Procedures (continued)

[redacted] *resident room The medication was unattended and unsecured.*

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

Immediately on 2/5/26 the medications found in non self-administering residents rooms were removed by the Health and Wellness Director. All medications were disposed of with the exception of the Desenex. An order for Desenex was in the residents chart and on MAR.

The Health and Wellness Director conducted an in-service on 3/4/26 for clinical staff in regards to residents self-administering and storage of medications. Also on 3/4/26 an audit was conducted by the clinical staff to ensure residents who are unable to self-administer medication had no medications in their rooms. The in-service included the requirement that medications must be secured and administered by staff unless a resident has documentation for self- administration.

The Health and Wellness Director or designee will conduct room audits weekly for 4 weeks and then bi-weekly for 2 weeks. Random audits monthly for 6 months.

Licensee's Proposed Overall Completion Date: *03/09/2026*

Implemented ([redacted] - 04/20/2026)