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

January 13, 2026

[redacted]
MARIA HALL, INC.
[redacted]

RE: MARIA HALL
190 MARIA HALL DR., 3RD FLOOR
DANVILLE, PA, 17821
LICENSE/COC#: 21521

[redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/04/2025 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: *MARIA HALL* **License #**: *21521* **License Expiration**: *11/08/2026*

Address: *190 MARIA HALL DR., 3RD FLOOR, DANVILLE, PA 17821*

County: *MONTOUR* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *MARIA HALL, INC.*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/26/1998* **Issued By**: *L&I*

Type: *I-2* **Date**: *05/24/2018* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *12/04/2025*

Inspection Dates and Department Representative

12/04/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *17* **Are 60 Years of Age or Older**: *17*

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

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

12/04/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/28/2025*

Inspections / Reviews *(continued)*

01/02/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/12/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/07/2026*

01/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/12/2026*

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

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

On [redacted] staff conducted medication cart audit. During the audit it was found that resident [redacted] had one extra [redacted] tablet. Based on the medication count completed [redacted] it was determined the resident did not receive the medication on [redacted]. Resident's medication administration record does not document that [redacted] was administered.

Resident [redacted] is prescribed [redacted] During the shift change narcotic count on [redacted] at 11:00P.M., it was determined resident # had [redacted] extra [redacted] The resident's medication administration record does not document the medication being administered on [redacted].
On [redacted] staff conducted medication cart audit. During the audit it was found that resident [redacted] had one extra [redacted] tablet. Based on the medication count completed [redacted] it was determined the resident did not receive the medication on [redacted] Resident's medication administration record does not document that [redacted] was administered.

On [redacted] the home conducted medication cart audit. During the audit it was found that resident [redacted] had one extra [redacted]. Based on the medication count completed [redacted] it was determined the resident did not receive the medication on [redacted]. Resident's medication administration record does not document that [redacted] was administered.
On [redacted] the home conducted medication cart audit. During the audit it was found that resident [redacted] had one extra [redacted]. Based on the medication count completed [redacted] it was determined the resident did not receive the medication on [redacted] Resident's medication administration record does not document that [redacted] was administered.
On [redacted] Resident [redacted] was not administered morning medications, including [redacted], [redacted], [redacted] and [redacted] Resident's medication administration record does not document the medications were administered.

Resident [redacted] is prescribed [redacted] 8:00P.M.. During the shift change narcotics count on [redacted] at 11:00P.M., it was determined resident # was short one [redacted]. Upon medication audit, it was determined Staff person A used an old paper copy of the resident's medication administration record to distribute medication on the morning of [redacted] The paper copy included the prior prescription which was Lyrica given at 8:00 AM. Staff person A administered the 8:00AM medication, which had been discontinued. Staff person A began using the electronic MAR later in the day which had the resident's current prescription of [redacted] at 8PM. That dosage was also administered according to the resident's electronic MAR, indicating two [redacted] were administered on [redacted] instead of one.

Plan of Correction ***Accept [redacted] - 12/29/2025)***

The medpasser (Med Tech, LPN, RN) is directly responsible for administering meds according to prescriber's orders. On the day these errors occurred the medpasser was an Agency nurse who could not get into the EMAR system, but did not call the Director of Resident Care whose number was posted in two obvious places. In addition, [redacted] was given uncorrected paper MARs to follow. When the DRC became aware of the errors and the reason, [redacted] notified the Agency that that nurse is no longer permitted to come to the facility. The staff person who gave the paper MARs

187d - Follow Prescriber's Orders (continued)

and did not contact the DRC was put on a personal improvement plan which includes [redacted] daily checking for notifications from the DRC. The same staffer is resuming monthly editing of paper MARs compared to EMARs to ensure they match. [redacted] will also perform weekly med cart audits while [redacted] is on nightshift.

The Administrator and DRC have updated the policy for orienting Agency medpassers new to the facility: they must come for orientation to the facility and med protocol for at least an hour before they may pass meds.

Following the updated policy for Agency medpassers and continuing the updates of paper MARs, combined with daily verification of meds by facility staff and DRC, will ensure ongoing compliance with prescriber's orders.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] - 01/13/2026)