



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

## Division of Drug Control

### Controlled Dangerous Substance (CDS)

#### Inspection Report

For

#### Assisted Living Facilities

### 1. License Information

Facility Name \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
OHCQ License Number \_\_\_\_\_ Expiration \_\_\_\_\_  
Maryland CDS Registration Number \_\_\_\_\_ Expiration \_\_\_\_\_  
Pharmacy Provider \_\_\_\_\_  
Inspection Date \_\_\_\_\_ Arrival Time \_\_\_\_\_

### 2. Security

Yes No N/A

- a. Does the facility have a policy and procedure to guard against theft and unlawful diversion of Controlled Dangerous Substances (CDS)?
- b. Is a specific individual responsible for the safety of CDS? If yes, who? \_\_\_\_\_
- c. Are all Schedule II and III CDS maintained under double lock?  
Who has access? \_\_\_\_\_  
(COMAR 10.07.14.29 O (3))
- d.. Does the staff count and record CDS before the end of every shift?  
(COMAR 10.07.14.29 O (1))
- e. In the event a discrepancy is noted during the above count, who is notified? \_\_\_\_\_
- f. Are all doses of CDS administered being properly documented?  
(COMAR 10.07.14.29 O (2))
- g. Are discontinued or unused CDS destroyed in the facility?  
If yes, how are they destroyed? \_\_\_\_\_  
Who is authorized to destroy? \_\_\_\_\_

**3. Record Keeping**

- a. Is a file of receipts for CDS received from the pharmacy maintained?  
Where is it maintained? \_\_\_\_\_
- b. If CDS are destroyed in the facility, are reports prepared and maintained?  
If yes, how long are they maintained? \_\_\_\_\_
- c. If destruction reports are being prepared, are they being forwarded to DDC?

**4. Inspection Summary**

Inspector comments and recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Actions required: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date required actions to be completed: \_\_\_\_\_

Nursing supervisor or designee: \_\_\_\_\_  
(print)

Signature of Nursing supervisor or designee: \_\_\_\_\_

Inspector: \_\_\_\_\_  
(print)

Signature: \_\_\_\_\_