

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Maple Ave. Los Angeles, CA 90011	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the safe storage and labeling of emergency potable (safe to drink or suitable for human consumption) water reserve for 204 out of 204 bottled waters, 34 six-pack bottled water cases (of which 12 six-packs with Niagara brand and 22 six-packs with [NAME] brand). By failing to: Ensure all emergency potable water was not stored past the facility applied label indicating a use by date (peak freshness and container integrity, not that the water itself has spoiled. Water does not expire, but plastic bottles can degrade over time and leach chemicals which affect the taste and safety) of 11/28/2025, as per facility policy and procedure (P&P) titled Emergency and Disaster Procedures dated 11/25/2025. This failure had the potential for all facility residents and staff consuming outdated emergency potable water in the event of an emergency, which could result in illness. Findings: During an interview on 7/6/2026 at 12:33 P.M., with the Dietary Supervisor (DS), the DS stated that the emergency water was used by the staff for drinking and was provided to residents as part of their meals during an emergency. The DS stated that emergency water was safe for consumption when it was labeled with the manufacturer's best by or use by date and was consumed in accordance with that date. The DS stated that the emergency water supply was an essential part of meeting resident's nutritional and hydration needs during an emergency. During an observation on 7/6/2026 at 12:40 P.M. in the facility's kitchen storage closet, the drinking emergency bottled water supplies were observed. 12 six -pack cases (72 one-gallon bottles) of Niagara (brand) purified drinking water were observed to have a manufacturer's date best by 3/30/2023 printed on the packaging with facility use by label dated 11/28/2025 and 22 of six-pack pack [NAME] (brand) 22 six-pack cases (132 one-gallon bottles) without manufacturer's date with facility label use by dated 11/28/2025. During a concurrent observation and interview on 7/6/2026 at 12:43 P.M., the DS stated it was unusual for the emergency bottled water to have a label indicating a date beyond the manufacturer's use by date. The DS stated that the manufacturer's Best if Used by date of March 30, 2023, indicated the water was approximately three years past that date. The DS stated that the facility applied labels indicated a use by date of November 28, 2025, and were not safe for use. The DS stated that emergency drinking water supplies had to be verified to ensure the water bottles were within the manufacturers' acceptable use by date before being provided to residents or staff. The DS stated that using emergency drinking water beyond the acceptable date could potentially harm residents and staff which could result in symptoms such as diarrhea, nausea, vomiting and stomach pain. The DS stated that all emergency water supply with a use by date 11/28/2025 had to be replaced as soon as possible. During a concurrent interview and record review on 7/6/2026 at 1:25 P.M. with the Infection Preventionist Nurse (IPN), photographs of the emergency water supply taken on 7/6/2026 were reviewed. The IPN stated that the emergency drinking water (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supply was intended for use by the residents and staff during an emergency. The IPN stated that the emergency drinking water had to be labeled to identify water intended for drinking, water intended for general use, and the applicable expiration or use by date. The IPN stated that the facility applied label indicated a use by date of 11/28/2025. The IPN stated that she agreed with the DS that all emergency water supplies stored in the kitchen storage area had to be replaced. The IPN stated if emergency water with a facility-applied use by date of 11/28/2025 were served, it could potentially cause gastrointestinal illness. The IPN stated that the facility failed to maintain a safe emergency drinking water supply. During a review of the facility's P&P titled Emergency and Disaster Procedures dated 11/25/2025, the P&P indicated the facility would have a written plan of action which included emergency menus to be used in the event of an emergency or disaster and indicated the procedure of rotating emergency water every year or longer. During a review of the facility's P&P titled Infection Prevention and Control Committee dated 11/25/2025, the P&P indicated that the facility had infection prevention and control program. The P&P indicated the duty of the committee included to assist in monitoring and assessing facility- wide environmental infection prevention and control practices. During a review of the facility's P&P titled Meals for All dated 11/25/2025, the P&P indicated meals for all plus a water supply was needed for emergency feeding.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect private health information for two of two sampled residents (Resident 30 and Resident 31), by failing to ensure confidential medical information was not easily visible and accessible. This failure had the potential to result in a violation of Resident 30 and 31's right to personal privacy and confidentiality of their medical records. Findings: During a review of Resident 30's admission Record, the admission Record indicated the facility originally admitted Resident 30 on 10/21/2013 and re-admitted the resident on 10/3/2025 with diagnoses including sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid) and dysphagia (difficulty swallowing food or liquid). During a review of Resident 30's History and Physical (H&P) dated 11/28/2025, the H&P indicated Resident 30 had the capacity to make medical decisions. During review of Resident 30's Minimum Data Set (MDS, a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 30 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and dependent (helper does all the effort) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 31's admission Record, the admission Record indicated the facility admitted Resident 31 on 6/5/2021 with diagnoses including schizophrenia (mental disorder in which people interpret reality abnormally), and depression (a mood disorder that causes persistent feeling of sadness and loss of interest). During review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31 had moderately impaired cognition for daily decision-making and mostly independent for ADLs. During a review of Resident 31's H&P dated 6/22/2026, the H&P indicated Resident 31 did not have the capacity to understand and make decisions. During a concurrent observation in the nursing station and interview on 7/8/2026 at 11:16 AM with the Director of Nursing (DON), Resident 30 and 31's electronic medical records (EMR-digital, computer-based version of patient's paper medical record) were left open and unattended on two computer screens. The DON was observed looking for the nurses and stated that the two nurses were busy attending to other residents. During an interview on 7/9/2026 at 8:04 AM with the DON, the DON stated importance of closing the EMR when walking out of the computer due to confidentiality and privacy issues. During a review of the facility's policy and procedure (P&P), titled, Resident Rights, reviewed on 11/25/2025, the P&P indicated that any unauthorized release, access, or disclosure of resident information was prohibited and had to be in accordance with current laws governing privacy of information issues. During a review of facility's P&P, titled, Confidentiality of Information and Personal Privacy, reviewed on 11/25/2025, the P&P indicated that the facility would protect and safeguard all resident personal and medical records.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) to meet the needs of two of 14 sampled residents (Resident 8 and Resident 10) by failing to:1. Develop a care plan for Resident 8's post-traumatic stress disorder (PTSD-a mental health condition triggered by experiencing or witnessing a terrifying event) diagnosis and Zyprexa (antipsychotic [medication that help calm the brain] medication) use.2. Develop a care plan for Resident 10's delusional (holding a strong, false belief that is completely out of touch with reality) thoughts of somatic (related to the body) symptoms behavior. These failures had the potential to result in a negative impact on Resident 8 and 10's health, as well as the quality of care and services received. Findings: During a review of Resident 8's admission Record, the admission Record indicated the facility admitted Resident 8 on 3/23/2026 with diagnoses including PTSD, anxiety and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive [period of feeling sad, hopeless or empty] lows to manic [being in a state of extreme, elevated energy and emotion] highs). During a review of Resident 8's Order Summary Report, dated 3/23/2026, the Order Summary Report indicated Resident 8 had a physician order for Zyprexa 5 milligram (mg) by mouth one time a day for psychosis (mental disorder) manifested by auditory/visual hallucinations. During a review of Resident 8's History and Physical (H&P) dated 3/24/2026, the H&P indicated Resident 8 had the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 8 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and mostly moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 8 had an active diagnosis of psychotic disorder and PTSD and taking high risk drug medication such as an antipsychotic medication. During a concurrent interview and record review on 7/9/2026 at 1:33 PM with Minimum Data Set Nurse (MDSN), Resident 8's care plan was reviewed. Resident 8's care plan indicated a missing PTSD care plan. MDSN stated Resident 8 was supposed to have had a care plan for PTSD to be able to provide individualized and specific care to Resident 8. During a concurrent interview and record review on 7/10/2026 at 11:03 AM with Director of Nursing (DON), Resident 8's care plan was reviewed. Resident 8's care plan indicated missing Zyprexa care plan. The DON stated importance of having Zyprexa care plan was to be able to provide and monitor Resident 8's Zyprexa use. The DON stated importance of needing to have PTSD care plan for Resident 8. During a review of Resident 10's admission Record, the admission Record indicated the facility originally admitted Resident 10 on 10/28/2025 and was re-admitted on [DATE] with diagnoses including schizophrenia (mental disorder in which people interpret reality abnormally), depression (a mood disorder that causes persistent feeling of sadness and loss of interest) and insomnia (sleep disorder). During a review of Resident 10's H&P dated 11/29/2025, the H&P indicated Resident 10 had the capacity to understand and make decisions. During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had intact cognition for daily decision-making and independent with ADLs. The MDS also indicated Resident 8 had an active diagnosis of schizophrenia and taking high risk drug medication such as an antipsychotic medication. During a review of Resident 10's Order Summary Report, dated 7/7/2026, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Order Summary Report indicated Resident 10 had a physician order for the following: Seroquel (antipsychotic medication) 12.5 mg by mouth one time a day and Seroquel 1 mg by mouth at bedtime for schizophrenia manifested by delusional thoughts of somatic symptoms. Resident 10's Order Summary Report also indicated a physician order to monitor behaviors of schizophrenia manifested by delusional thoughts of somatic symptoms, tally with numerical value and document interventions such as rest/reposition; cues/prompt/reassure; redirection/diversion/reorientation and other every shift. During a concurrent interview and record review on 7/10/2026 at 11:03 AM with the DON, Resident 10's care plan was reviewed. Resident 10's care plan indicated missing behavior of delusional thoughts of somatic symptoms care plan. The DON stated that the physician had recently changed the behavior manifestation and that the care plan should have been updated as well in Resident 10's care plan. The DON stated importance of care planning Resident 10's behavior to be able to provide proper care to Resident 10. During a review of facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered reviewed on 11/25/2025, the P&P indicated that a comprehensive care plan had to be developed and implemented for each resident including measurable objectives and timetables to meet a resident's physical, psychosocial and functional needs. During a review of facility's P&P titled Behavioral Assessment, Interventions and Monitoring reviewed on 11/25/2025, the P&P indicated that facility was to provide and residents would receive behavioral health services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with comprehensive assessment and plan of care. P&P indicated that the care plan was to incorporate findings from the comprehensive assessment and be consistent with the current standards of practice.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide an environment that was free from accidental hazards for one of five sampled days (7/10/2026) by failing to ensure the facility's front door was locked. This failure had the potential to result in residents wandering out of the facility, elopement (when a resident leaves/escapes from a facility without a physician's order and without the staff knowing) and vulnerability to external intruders entering the facility. Findings: During a concurrent observation and interview on 7/10/2026 at 8:16 AM with Registered Nurse 1 (RN 1), in front of the facility entrance, the front door was observed to be unlocked, and the surveyor was able to enter the facility. RN 1 observed surveyor entered the facility and asked how the surveyor was able to enter the facility from the outside. RN 1 also stated that the front door was supposed to be locked and was supposed to alarm when opened without a code. During a follow up interview on 7/10/2026 at 9:50 AM with RN 1, RN 1 stated the facility front door was supposed to be locked due to having psychiatric residents (residents with mental health conditions that affect their ability to think and act normally). RN 1 stated facility staff were supposed to let all visitors in using the facility code. RN 1 also stated that the front door could not be opened without the facility code and did not know why the front door was unlocked that morning (7/10/2026). During an interview on 7/10/2026 at 10:17 AM with the Director of Nursing (DON), the DON stated that the front door was supposed to be locked and visitors were to be let in by the facility staff using the code, which unlocked and opened the door. The DON stated that if the door was locked and was opened from the inside, the front door alarm turned on to alert staff. The DON stated the facility was a secured facility (locked or protected living environment designed to keep residents with memory loss from wandering) and residents could wander out of the facility if the door was unlocked and did not alarm. During a review of the facility's policy and procedure (P&P), titled, Behavioral Health Services, reviewed on 11/25/2025, the P&P indicated that it was the facility's policy to maintain a safe, secure and therapeutic environment for residents residing in the behavioral/dementia (a decline in mental abilities such as memory, thinking, and reasoning, that is severe enough to interfere with daily life) unit and that doors leading into and out of the building had to be locked when necessitated by the clinical needs of the residents or to prevent security threats. During a review of the facility's P&P, titled, Wandering and Elopements, reviewed on 11/25/2025, the P&P indicated that the facility would identify residents who were at risk of unsafe wandering and elopement and strived to prevent harm. During a review of the facility's P&P, titled, Safety and Supervision of Residents, reviewed on 11/25/2025, the P&P indicated that facility strived to make the environment as free from accident hazards as possible and that resident safety and supervision and assistance to prevent accidents were facility-wide priorities.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to update and post daily the actual hours or projected hours worked by licensed and unlicensed staff providing direct care to the residents per shift on one of five sampled days (7/6/2026), as per the facility's policy and procedures (P&P) titled Posting Direct Care Daily Staffing Numbers, reviewed on 11/25/2025. This failure had the potential to prevent residents and visitors from knowing the accurate nurse staffing hours and had the potential to cause inadequate staffing and had the potential for the residents' needs to go unmet. Findings: During an observation on 7/6/2026 at 7:44 AM, in front of the nursing station, a facility document titled Census (number of residents currently staying or residing at the facility) and Direct Care Services Hours Per Patient Day (DHPPD-amount of hands-on nursing time each patient gets within a 24-hour period) was observed posted and dated 7/2/2026 with only the estimated direct care services hours and DHPPD. During an interview on 7/10/2026 at 10:17 AM with the Director of Staff Development (DSD), the DSD stated projected nursing hours were supposed to be posted daily and updated as needed if there were any changes with the census and staffing. The DSD stated that the charge nurse on the weekend should have updated the nursing hours to be able to provide the most recent staffing hours. During an interview on 7/10/2026 at 12:04 PM with the Director of Nursing (DON), the DON stated importance of updating and posting nursing hours daily and added that facility missed posting the nursing hours from 7/3/2026 to 7/5/2026. During a review of the facility's P&P, titled, Posting Direct Care Daily Staffing Numbers, reviewed on 11/25/2025, the P&P indicated the facility would post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The P&P indicated that within two hours of the beginning of each shift, the number of licensed nurses (Registered Nurses [RNs], Licensed Vocational Nurses [LVNs]) and the number of unlicensed nurses (certified nursing assistants [CNAs] and nursing assistants [Nas]) directly responsible for resident care was to be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review the facility failed to clarify physician orders for Eliquis (a prescription blood thinner) as recommended by the facility's consultant pharmacist (a healthcare professional who provides specialized expertise to healthcare facilities, typically focusing on ensuring the safe and effective use of medications) during the monthly Medication Regimen Review (MRR, when a consultant pharmacist reviews and analyzes a resident's medication list, ensuring that the medications are appropriate, effective, and safe) for one of six sampled residents (Resident 2). This failure had the potential for Resident 2 to experience adverse effects (undesired and harmful effects that occur because of a medication, treatment, or procedure) from Eliquis such as bruising, balance issues, and hemorrhage (uncontrolled bleeding). Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 1/9/2025 with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), and depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). During a review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 4/27/2026, the MDS indicated Resident 2 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and could not make daily decision for self-requiring total assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 2's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 5/18/2026 for Eliquis 5 milligrams (mg, a metric unit of volume) by mouth daily for CVA PPX (Cerebrovascular [stroke; death of brain tissue] prophylaxis [preventative treatment]). During a review of Resident 2's Consultant Pharmacist's Medication Regimen Review (CPMRR) Prescriber note, dated 6/5/2026, CPMRR Prescriber note indicated a recommendation to re-evaluate Resident 2's Eliquis and clarify CVA PPX due to a possibility of an unnecessary therapy. The CPMRR Prescriber note indicated a need to explain how benefits outweighed the risk of the therapy. During a concurrent interview and record review on 7/10/2026 at 1:30 PM, Resident 2's physician order for Eliquis (Apixaban) dated 5/18/2026 and the facility's document titled Consultant Pharmacist's Medication Regimen Review dated 7/6/2026 were reviewed with the Director of Nursing (DON). The DON verified the facility's pharmacy consultant recommended to clarify the intended indication for use of Eliquis for CVA Prophylaxis. The DON stated Resident 2's current physician order should have been clarified. The DON stated she did not know why Resident 2's physician order for Eliquis was not clarified. The DON stated that when the pharmacist recommends changes to the resident's medication, the recommendation had to be followed through because medications had adverse effects. The DON stated there could have been potential for Resident 2 to experience adverse effects if the pharmacist recommendations are not followed. The DON further stated following the pharmacist recommendations could help prevent the resident from experiencing adverse effects of medications. During a concurrent interview and record review on 7/10/2026 at 2:05 PM, Resident 2's facility document titled Consultant Pharmacist's Medication Regimen Review dated 6/5/2026 were reviewed with Licensed Vocational Nurse (LVN) 2. LVN 2 verified and confirmed the consultant pharmacist recommended to clarify the reason for usage of Eliquis. LVN 2 stated Resident 2's current physician order for Eliquis was unchanged and had not been clarified. LVN 2 stated that when the consultant (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacist made a recommendation, the resident's physician had to be notified of the recommendation. LVN 2 stated Resident 2's physician order should have been clarified with the resident's physician as recommended by the consultant pharmacist. LVN 2 stated consultant pharmacist recommendations had to be followed to help prevent the resident from having unwanted side effects. During a review of the facility's Policy and Procedure (P&P) titled Drug Regimen Review reviewed 11/25/2025, the P&P indicated Facility must ensure that a pharmacist reviews each resident's medical chart every month and perform a drug regimen review. During their monthly drug regimen review, pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports will be acted upon by the facility.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain infection control measures necessary to prevent the possible spread of infections for one of two sampled medication carts (medication cart 1-med cart 1). By failing to ensure the incinerator container (medication disposal container) was kept clean, closed and/or changed as needed. This failure had the potential to result in the spread of disease and infection to residents, visitors, and staff. Findings: During a concurrent observation and interview on 7/8/2026 at 10:20 AM with Licensed Vocational Nurse 2 (LVN 2) of med cart 1, the bottom drawer was observed with an opened incinerator container, which was more than 80% full of reddish, and brownish unknown substance with some pieces of capsules in it. The incinerator container was also observed unclean, with reddish and brownish residuals and dried spills all over the top lid. LVN 2 stated that the incinerator container should have been closed due to possible spillage of the unknown substance and should have been clean for infection control. LVN 2 stated that since the incinerator container was almost full, she (LVN 2) was supposed to have changed the container. During an interview on 7/8/2026 at 10:41 AM with the Infection Preventionist Nurse (IPN), the IPN stated that the incinerator had to be closed and clean for possible infection control and contamination issues. During an interview on 7/9/2026 at 8:04 AM with the Director of Nursing (DON), the DON stated that the observed incinerator container in med cart 1 had to be closed, cleaned and changed as needed. During a review of the facility's policies and procedures (P&P) titled Infection Prevention and Control Program, reviewed on 11/25/2025, the P&P indicated that the facility an established and maintained infection prevention and control program that provided a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. During a review of the facility's P&P titled Discarding and Destroying Medications, reviewed on 11/25/2025, the P&P indicated that medications that could not be returned to the dispensing pharmacy were disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. The P&P indicated that for unused, non-hazardous controlled substances not disposed of by an authorized collector, EPA (Environmental Protection Agency-United States government agency that protect human health and environment) recommended destruction and disposal of the substance with other solid waste by mixing medication, either liquid or solid, with an undesirable substance such as sand, coffee grounds, kitty litter or other absorbent materials.		