Division	of Health Service Reg	ulation			FORI	MAPPE
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 00VC 1800-00-07-058004815	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
					COMPI	
		MHL041-880	B. WING		05/	17/2018
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE, ZIP CODE		
ALL ABO	UT YOU RESIDENTIAL F	JONIE CARE LLC	OINT, NC 27260			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMP DA
V 000	INITIAL COMMENTS	3	V 000			
	An annual survey was Deficiencies were cite	s completed on 5/17/2018. ed.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
V 536	27E .0107 Client Righ Int.	ets - Training on Alt to Rest.	V 536			
	10A NCAC 27E .0107 ALTERNATIVES TO F INTERVENTIONS					
	to restrictive intervention	ize the use of alternatives ons.		see page 4		
	<ul><li>(b) Prior to providing s disabilities, staff includ employees, students o demonstrate competer</li></ul>	r volunteers, shall				
j	completing training in control of the completing training the complete strategies for creating the complete in the complete straining the complete straining the complete straining training the complete straining training trainin	communication skills and ating an environment in imminent danger of abuse		Dross		
	or injury to a person wit property damage is pre	th disabilities or others or evented.		RECEIVED		
; (	<ul><li>c) Provider agencies s</li></ul>	shall establish training		Jul 6 0 2013		
9	compliance and demon pathered.	encies, monitor for internal istrate they acted on data		DHSR-MH Licensure Sec	et	
ir	d) The training shail be nolude measurable lea neasurable testing (wri	e competency-based, ming objectives, tten and by observation of				
þ	ehavior) on those obje nethods to determine p	ctives and measurable				
l c	ourse.					
(e	<ul> <li>e) Formal refresher tra y each service provide</li> </ul>	ining must be completed r periodically (minimum				
a	nnually). ) Content of the training				I	
of Health	Service Regulation					
Han		PLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) I	DATE
FORM	1 mg		689n M965	Q.p.	7/5	118

Division of Health Service	Regulation				RM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	71	CONSTRUCTION		E SURVEY PLETED
	MHL041-880	B. WING		0.5	/17/2018
NAME OF PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY, STA	TE, ZIP CODE	1 03.	717/2016
ALL ABOUT YOU RESIDENTL	AL HOME CARE LLC 1103 C	ARTER STREET			
	HIGH	POINT, NC 27260			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 536   Continued From p	page 1	V 536			
provider wishes to the Division of Mi-Paragraph (g) of the Gollowing core are (1) knowled people being server. (2) recognize behavior; (3) recognize external stressors disabilities; (4) strategies relationships with procession organizational factor disabilities; (6) recognizity organizational factor disabilities; (6) recognizity organizational factor disabilities; (6) recognizity assisting in the perfect decisions about the (7) skills in a escalating behavior (8) communication de-escalating period (9) positive by means for people we activities which direst behaviors which are (h) Service provided documentation of in at least three years. (1) Document (A) who particity outcomes (pass/fail) (B) when and (C) instructors.	semploy must be approved by I/DD/SAS pursuant to his Rule. nonstrate competence in the as: ge and understanding of the ed; ing and interpreting human ing the effect of internal and that may affect people with s for building positive persons with disabilities; and cultural, environmental and post that may affect people with the importance of and son's involvement in making pir life; assessing individual risk for the cation strategies for defusing potentially dangerous behavior; the disabilities to choose culy oppose or replace the unsafe). The shall maintain the training and the pated in the p	V 536	See page 4		

Division	of Health Service Requ	ulation			FOR	RM APPROVE		
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		PLETED			
					1			
		MHL041-880	B. WING		25	470040		
NAME OF S	PROVIDER OR SUPPLIER					/17/2018		
	NOVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE				
ALL ABO	UT YOU RESIDENTIAL H	UME CARE LLC	RTER STREET					
		HIGH PO	DINT, NC 27260					
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETE		
		,	1 1 1 1 1	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE		
V 536	Continued From page	2	1/	,		-		
			V 536			İ		
	(i) Instructor Qualifica	tions and Training	1 1			1		
	Requirements:							
	(1) Trainers sha	II demonstrate competence						
	by scoring 100% on te	sting in a training program						
8	aimed at preventing, re	educing and eliminating the				i		
	need for restrictive inte							
	(2) Trainers sha	Il demonstrate competence						
!	by scoring a passing g	rade on testing in an						
l	instructor training prog		1 1					
ļ	(3) The training		1		į.			
ĺ	competency-based, inc	clude measurable learning			)			
	objectives, measurable	testing (written and by			i			
	massivation of denavio	r) on those objectives and	1					
ļ	measurable methods to	determine passing or						
	failing the course. (4) The content of	-fall						
1		of the instructor training the		see page 4				
	service provider plans i	on of MH/DD/SAS pursuant		See press	1			
	to Subparagraph (i)(5)	of this Pulo			1			
		structor training programs	İ					
	shall include but are no	t limited to presentation of:			1			
	(A) understanding	the adult learner;			Ţ			
	(B) methods for to	eaching content of the						
	course;	oboling content of the	!!!		1	!		
1,	(C) methods for e	evaluating trainee				- 1		
11	performance; and	3			!	İ		
Į į	(D) documentation	procedures.						
1	(6) Trainers shall	have coached experience			Į.			
t	teaching a training prog	ram aimed at preventing,			ļ	1		
ļſ	reducing and eliminating	the need for restrictive	1					
i	nterventions at least on	e time, with positive			ļ	- 1		
r	review by the coach.				1	- 1		
1 '	7) Trainers shall	teach a training program			1	1		
a	aimed at preventing, red	lucing and eliminating the			1	1		
	need for restrictive inten-	ventions at least once	1		1			
	annually.				j	1		
1000	<ol><li>Trainers shall (</li></ol>	complete a refresher			1	- 1		
ir	nstructor training at leas	it every two years.				- 1		
(0	<ul> <li>Service providers sha</li> </ul>	all maintain			Ĩ	1		
					1			
ion of Health	Service Regulation							

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY
		MHL041-880	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	SIDERT	1000000		0	5/17/2018
			ADDRESS, CITY, S			
ALLABOI	UT YOU RESIDENTIAL	TOME OFFICE LLC	ARTER STREET OINT, NC 27260			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D BE	COMI DA
V 536	Continued From pag	je 3	V 536			
İ			V 536			
į	training for at least th	tial and refresher instructor		1		Ì
1	(1) Docum	entation shall include:				1
1		pated in the training and the				1
1	outcomes (pass/fail);	bated in the training and the	1			
		where attended; and				i
1.00	(C) instructor's	name				
		n of MH/DD/SAS may	İ			
10	request and review th	nis documentation any time.				ļ
	(k) Qualifications of (	Coaches:				
		all meet all preparation				
i 1	requirements as a tra	iner.				
	(2) Coaches sh	all teach at least three times				1
1	he course which is be	eing coached.				
	<ol><li>Coaches sh</li></ol>	all demonstrate				1
	competence by compl	etion of coaching or				
	rain-the-trainer instru		1			
10	Documentation sha	all be the same preparation				i
· a	s for trainers.					
I i			1			
			1			
1			1			
İ						
; T	his Rule is not met a	s evidenced by:		Staff participated in	NCI	-1-1
В	ased on record review	vs and interviews, the		Staff participated in training on 5/19/201	! :	5/19/
fa	cility failed to ensure	staff received refresher	1 1-	training on 3/19/201	°	
l tra	aining on alternatives	to restrictive interventions		and certificates we	ve !	
at	least annually affecti	ng 2 of 3 surveyed staff	1	and certific coast	ch	
(#	1 & the Qualified Prof	fessional (QP)). The		awarded and filed	1.71	
fin	dings are:	( //.		respective staff reco	rds.	
			1	respective state		
Re	eview on 5/17/2018 of	f staff #1's employee file				
rev	vealed:		}		1	
	lire date: 5/23/2018;					
- D	ocumentation that tra	aining on alternatives to	1			
res	strictive interventions	had expired on			Ì	
3/1	8/2017;		1		1	
- N	o documentation of re	efresher training on				
of Health S						

Divisio	n of Health Service Reg	ulation				ORM APPROVE
STATEME AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		ATE SURVEY
		MHL041-880	B. WING			0.5(4.7)0 - 4 -
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	OTE ZIR CORE		05/17/2018
ALLAR	OUT YOU RESIDENTIAL F		ARTER STREET	ATE, ZIP CODE		
7,227,6	OUT TOO RESIDENTIAL P	TOTAL CARE LLC	POINT, NC 27260			
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF C	CRRECTION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFiX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	IN SHOULD BE E APPROPRIATE	COMPLETE DATE
V 536	Continued From page	2 4	V 536			
	alternatives to restrict	ive interventions.	l			
	Review on 5/17/2018 revealed: - Hire date: 2/28/2011 - Documentation that restrictive intervention - No documentation of alternatives to restrictive intervention of alternatives on 5/16/2018	of the QP's employee file ; training on alternatives to s had expired on 5/5/2013; frefresher training on we interventions.  B with staff #1 revealed: er training on alternatives				
	an administrative assistable - She had talked to the (CEO) about scheduling training on alternatives in the near future; - She was responsible for trainings were up to date.	to the role of QP in ing previously worked as tant; Chief Executive Officer g all facility staff for to restrictive interventions for ensuring facility staff e;		see page	-{	
V 537 2	date; The Management Com for QP services kept up v	aff trainings on interventions were up to	V 537			
	ECLUSION, PHYSICAL	RESTRAINT AND			,	1
		3.1.5.000				1
m or mealth	Service Regulation					

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D PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(V2) DA	E OUBLIEN
	o. Connection	IDENTIFICATION NUMBER:				E SURVEY IPLETED
		MHL041-880	B. WING			
ME OF P	PROVIDER OR SUPPLIER	STORET	22222		1 0:	5/17/2018
			DDRESS, CITY, STA	TE, ZIP CODE		
LABO	UT YOU RESIDENTIAL H	CHILL CHILL ELEC	RTER STREET DINT, NC 27260			
X4) ID REFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAI	N OF CORRECTION	
TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE	ACTION SHOULD BE	(X5)
			TAG	DEFIC	TO THE APPROPRIATE	DATE
V 537	Continued From page	5	V 537		**************************************	
	ISOLATION TIME-OU		0 337			i
- 1						
	time-out may be small	al restraint and isolation				
1	been trained and have	oyed only by staff who have				1
	competence in the	e demonstrated	1			
ĺ	to these procedures	per use of and alternatives Facilities shall ensure that				
	staff authorized to omr	ploy and terminate these	!			į
ļ	procedures are retrain	ed and have demonstrated				
1	competence at least a	ed and have demonstrated	1			
- 1	(b) Prior to providing di	irect care to people with				1
ļ	disabilities whose treat	ment/habilitation also				
	includes restrictive inte	rventions, staff including				
i:	service providers, emp	lovees students or				
	volunteers shall comple	ete training in the use of				l
į;	seclusion, physical rest	traint and isolation time-out				İ
! ;	and shall not use these	Interventions until the				 
l t	training is completed ar	nd competence is		See Page	4	
1	demonstrated.	To componente 13	i	see page	1	
(	c) A pre-requisite for ta	aking this training is				
0	demonstrating compete	nce by completion of				
t	raining in preventing, re	educing and eliminating				
t	he need for restrictive i	nterventions	1			
(	d) The training shall be	competency-based				
ir	nclude measurable lear	ning objectives.			i	
l n	neasurable testing (writ	ten and by observation of				
Ь	ehavior) on those object	ctives and measurable	1			
'n	nethods to determine pa	assing or failing the				
C	ourse.	7				
(€	e) Formal refresher train	ining must be completed	1			
þ.	y each service provider	periodically (minimum	1		i	
aı	nnually).	1921 92			ļ	
(f)	) Content of the training	g that the service	1			
pr	ovider plans to employ	must be approved by				
! th	e Division of MH/DD/S/	AS pursuant to				
Pa	aragraph (g) of this Rul	e.	1			
(g	) Acceptable training p	rograms shall include.	ļ			
h	it are not limited to, pre		1			
100		sentation of:	ı			
(1)	) refresher inform e use of restrictive inter	nation on alternatives to				

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Division	of Health Service Regu				FOR	RMAPPROV
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	to the second to the	E CONSTRUCTION		SURVEY
			A. BUILDING:		COMI	PLETED
		MHL041-880	a. WING		0.5	47/2040
NAME OF	PROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STA	ATE ZIPCODE	1 05	/17/2018
ALL ABO	OUT YOU RESIDENTIAL H		RTER STREET	WE, Ell GODE		
		HIGH PC	DINT, NC 27260			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 537	Continued From page	6	V 537			
(2) by tee	(2) guidelines or (understanding immine others); (3) emphasis on rights and dignity of all concepts of least restriincremental steps in an (4) strategies for of restrictive intervention which increasessment and monitor psychological well-bein use of restraint through restrictive intervention; (6) prohibited pro (7) debriefing stratim portance and purpose (8) documentation of initial at least three years. (1) Documentation (A) who participate outcomes (pass/fail); (B) when and when (C) instructor's natical contents of the distriction of eview/request this documents: 1) Trainers shall of y scoring 100% on testifitied at preventing, reduced for restrictive intervence (ed for restrictive intervence)	n when to intervene ent danger to self and a safety and respect for the persons involved (using ictive interventions and intervention); the safe implementation ons; hergency safety lude continuous oring of the physical and g of the client and the safe out the duration of the icedures; altegies, including their e; and in methods/procedures, all maintain and refresher training for in shall include: ed in the training and the ere they attended; and me. If MH/DD/SAS may mentation at any time, in and Training in a training program using and eliminating the entions.	V 537	See page 4		

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PRINTED: 05/21/2018 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO

VIAO LEM	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUR COMPLETS	
		MHL041-880	B. WING		05/47/	20
NAME OF	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, ST.	ATE ZID CODE	05/17/2	20
ALL ARO	OUT VOU DECIDENT		RTER STREET	ATE, ZIP CODE		
ALL ABO	OUT YOU RESIDENTIAL HO	THE CARE ELC	INT, NC 27260			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS-REFERENCE).	IDBE I	co
V 537	Continued From page	7	V 537			-
(   (   (   (   (   (   (   (   (   (	(3) Trainers shall by scoring a passing grainstructor training programmers are competency-based, inconsidering the course.  (4) The training second considering the course observation of behavior measurable methods to failing the course.  (5) The content of service provider plans to approved by the Division to Subparagraph (j)(6) of constant of the course of the course;  (A) understanding methods for the course;  (C) evaluation of the course;  (C) evaluation of the course;  (C) evaluation of the course;  (D) documentation of the course;  (C) evaluation of the course of sectusion, physical residence, as specified in Faule.  (B) Trainers shall be course two times with a postoach.  (B) Trainers shall the second course of restrictive intervent neutrally.  (C) Trainers shall to structor training at least of service providers shall course of the cours	I demonstrate competence rade on testing in an animam.  Ishall be allude measurable learning testing (written and by and of determine passing or an animam a	V 537	See page 4		

STATE FORM

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL041-880	B. WING		0.4	1471004
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E. ZIP CODE	1 0:	5/17/2018
ALL ABO	UT YOU RESIDENTIAL		RTER STREET	-,		
		HIGH P	DINT, NC 27260			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMP DA
V 537	Continued From pag	ge 8	V 537	,		+
	training for at least the course of the cour	where they attended; and a name. In of MH/DD/SAS may ocumentation at any time. Coaches: Interest all preparation either. Interest all demonstrate letton of coaching or ction. Interest all be the same		See page 9		
find the state of	acility failed to ensure raining in seclusion, p solation time out at leasureyed staff (#1 & th QP)). The findings and evelope of the training	ws and interviews, the staff received refresher hysical restraint and ast annually affecting 2 of 3 are Qualified Professional e:  of staff #1's employee file aining in seclusion, solation time out had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL041-880	B. WING		05/17	/204¢
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	1 03/1/	12010
ALL ABO	OUT YOU RESIDENTIAL	HOME CARE LLC 1103 C	ARTER STREET			
		HIGH P	OINT, NC 27260			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	COMF DA
V 537	Continued From pag	e 9	V 537		1	_
	Review on 5/17/2018 revealed: - Hire date: 2/28/201 - Documentation that physical restraint and expired on 5/5/2013; - No documentation of seclusion, physical restraint and out.  Interview on 5/16/201 - She received refrest physical restraint and Interview on 5/17/201 - She had transitioned January 2018 after had an administrative assistant and isolation time out in the seclusion of the seclusi	8 of the QP's employee file 1; t training in seclusion, d isolation time out had of refresher training in estraint and isolation time 18 with staff #1 revealed: ther training in seclusion, isolation time out annually. 8 with the QP revealed: to the role of QP in living previously worked as stant; e Chief Executive Officer ing all facility staff for eclusion, physical restraint in the near future; for ensuring facility staff		See page 4		

Multi-Therapeutic Serv.



## MULTI-THERAPEUTIC SERVICES, INC.

FACSIMILE T	RANSMITTAL SHEET	
TO:	FROM:	
Clarice Rising, MSW, LCSW	Nancy Cruz, BA, Q.1	p <sub>.</sub>
COMPANY:	DATE:	
Mental Health Licensure & Cert. Sect.	7/7/2018	
FAX NUMBER:	TOTAL NO. OF PAGES, INCLUDE	NG COVER:
919-715-8078	11	
PHONE NUMBER:	SENDER'S PHONE NUMBER:	
	336-778-2520	
R(g:	SENDER'S FAX NUMBER:	
1103 CARTER ST. GROUP HOME SINNUGL SURVEY	336-778-2521	
☐ URGENT ☐ FOR REVIEW ☐ PLEASE CO	DMMENT X PLEASE REPLY	□ PLEASE RECYCLE
NOTES/COMMENTS:		
Thanks for your assistance.		
Nancy Cruz, BA, Q.P.		RECEIVED

JUL C 9 2013

**DHSR-MH Licensure Sect**