	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII			E CONSTRUCTION		SURVEY PLETED
				A. BUILDING.			
		MHL011-390		B. WING		07/	18/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CEN	NTER FOR SPIRITUA	L EMERGENCE &		TH LOUISIAN LE, NC 2880	IA AVENUE, SUITES D3 & D4 6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	ΓS		V 000			
	on 7/18/18. The co (Intake # NC14067	nplaint survey was complaint was unsubst 2). Deficiencies wer 3600 program was 2	antiated e cited.				
	This facility is licensed for the following service categories: 10A NCAC 27G .1100 Partial Hospitalization for Individuals who are Acutely Mentally III. 10A NCAC 27G .3700 Day Treatment for Individuals with Substance Abuse Disorders. 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program. 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups. 10A NCAC 27G .3600 Outpatient Opioid Treatment.						
V 233	provides periodic sindividual an oppor changes in his lifes other medications a treatment in conjun rehabilitation and m (b) Methadone and for use in opioid tredetoxification and m opioid dependent in (c) For the purpose and other medication treatment shall be a doses for a period (d) For individuals	SO1 SCOPE pioid treatment facili ervices designed to e tunity to effect consti- tyle by using methac approved for use in e ciction with the provis- nedical services. d other medications a atment are also tool ehabilitation process	offer the ructive done or opioid ion of approved in the of an ethadone et in opioid easing ays.	V 233			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL011-390		B. WING		07/	18/2018
	PROVIDER OR SUPPLIER	_ EMERGENCE &	370 NOR		STATE, ZIP CODE NA AVENUE, SUITES D3 & D4 16	4	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 233	methadone and oth use in opioid treatm maintenance treath methadone and oth use in opioid treatm dispensed in exces	ge 1 re admission to the ster medications appropent may also be used the medications appropent. In these cases were medications appropent may be administed to 180 days and stable and clinically estable.	oved for ed in , oved for tered or nall be	V 233			
	facility failed to prove medical services for (Client #5 and Client Record review on 7-Admission date of -Diagnoses include Sedative Use Disorder, Post-Trau Borderline Personal-Intake physical assignated 11/22/17 note Psychiatrist-no medicand Gabapentin in -Controlled Substant revealed no control-Monthly Urine Drugfor amphetamines amonth since admit -Treatment Plan da"Integrate treatment with opioid treatment Care Physician (PC)	views and interviews vide coordination of or 2 of 14 sampled clint #6). The findings of 1/16/18 for Client #5 if 11/22/17. d: Opioid Use Disorder, Depression, Animatic Stress Disord lity Disorder and Agosessment by Medical ed client "was followeds." Had been on Repast. Ince Report dated 11/1ed prescriptions. Ince Streens (UDS) we and/or Benzodiazepid	care with ents are: revealed: der, xiety er, oraphobia. Director ed by emeron 27/17 re positive nes each a goals of: al issues Primary providers				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL011-390		B. WING		07/	18/2018
	PROVIDER OR SUPPLIER	EMERGENCE &	370 NORT		STATE, ZIP CODE NA AVENUE, SUITES D3 & D 16)4	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 233	Address co-occu anxiety and ADHD.' -While counseling repositive UDS there a PCP or mental health profes. Record review on 7-Admission date of -Diagnoses include Hypertension, Insul Diabetes, Hyperlipid RefluxPhysician ordered Atorvastatin, Lisino and AmitriptylineTreatment Plan da "integrate treatmen with opioid treatmen with opioid treatmen methadone clinic in director regarding Enhigh QT prolongation medical issues/medical is	rring mental health issolves revealed discussions was no indication of relation of relation of resalth professionals. In the force of	sion of eferral to CP or vealed: er, ophageal Levemir, pentin a goal to sues al nedical ntinued olex e with ed: opin 4mg ell as efic 1 month	V 233			

Division of Health Service Regulation

STATE FORM 6899 K1H511 If continuation sheet 3 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		COMPLETED		
		MHL011-390		B. WING		07/·	18/2018
	PROVIDER OR SUPPLIER	EMERGENCE &	370 NOR1		STATE, ZIP CODE IA AVENUE, SUITES D3 & D4 6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 233	and while his anxiet take anything for it"His sugar had been now." Interview on 7/17/17 revealed: -There was no EKG-"QTC was just one end all to maintain a-"We should coordicare" for Client #6"We look at COWs potential." Interview on 7/18/17 revealed: -"I looked into Client an actual referral."	ty had increased he en out of whack but we with the Medical D amachine here.	was stable irector it not the rimary c	V 233			
V 238	TREATMENT. OPE (e) The State Author approval on the following (1) compliance (2) compliance (2) compliance standards of practice (3) programs service delivery; and (4) impact on treatment services (f) Take-Home Elig comprehensive ma	incomplete the delivery of opio in the applicable popion the delivery of opio in the applicable popion the app	PIOD ram federal sful id oulation.	V 238			

Division of Health Service Regulation

STATE FORM 6899 K1H511 If continuation sheet 4 of 12

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL011-390	B. WING		07/18/2018	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0//1	0/2010
	NTER FOR SPIRITUAL	EMERGENCE & 370 NORT	, ,	IA AVENUE, SUITES D3 & D4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 238	methadone or othe treatment of opioid specified requirement reatment. The clie requirements for continuous attend a minimum of month. After the fir years of continuous attend a minimum of month. (1) Levels of following conditions (A) Level 1. If continuous treatmel limited to a single of shall ingest all other the clinic; (B) Level 2. continuous prograngranted for a maximand shall ingest all at the clinic each w (C) Level 3. treatment and a micontinuous progranclient may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses a under supervision and client may be grant take-home doses and client may be grant t	r medications approved for addiction must meet the ents for time in continuous and must also meet all the ontinuous program compliance rate such compliance during periods immediately preceding. In addition, during the first treatment a patient must of two counseling sessions per est year and in all subsequent a treatment a patient must of one counseling session per Eligibility are subject to the second to the supply is ose each week and the client r doses under supervision at After a minimum of 90 days of a compliance, a client may be num of three take-home doses other doses under supervision	V 238			

	SURVEY PLETED
MHL011-390 B. WING 07/	18/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE CENTER FOR SPIRITUAL EMERGENCE & 370 NORTH LOUISIANA AVENUE, SUITES D3 & D4 ASHEVILLE, NC 28806	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 238 treatment and a minimum of 180 days of continuous program compiliance, a client may be granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week; (F) Level 6. After two years of continuous treatment and a minimum of one year of continuous program compiliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and (G) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compiliance, a client may be granted for a maximum of 30 take-home doses and shall ingest at least one dose under supervision at the clinic every nonth. (2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility; (A) A client's take-home eligibility is reduced or suspended for evidence of recent drug abuse. A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility suspended; and (C) The reinstatement of take-home eligibility; (B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility suspended; and (C) The reinstatement of take-home eligibility: (A) A client the first two years of continuous treatment Program. (3) Exceptions to Take-Home Eligibility: (A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of exceptional circumstances such as illness, personal or family crisis, travel or other hardship may be permitted a temporarily reduced schedule	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDFLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMP	LLTLD
		MHL011-390	B. WING		07/1	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
THE CEI	NTER FOR SPIRITUAL	EMERGENCE 8 370 NOR	TH LOUISIAN	NA AVENUE, SUITES D3 & D4		
THE CEI	TER FOR SPIRITUAL	ASHEVIL	LE, NC 2880	06		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 238	V 238 Continued From page 6				ļ	
V 230	found to be response Except in instances verifiable physical of 13 take-home do period during the fir treatment. (B) A client wapplicable mandato verifiable physical cadditional take-home authority. Clients watake-home eligibility disability may be gradicational take-home dosage medications approvadication shall be aphysician on an induction to the following: (A) An addition methadone or other treatment of opioid to each eligible client reatment of opioid to any eligible client restriction shall not receiving take-home above. (g) Withdrawal Froo Opioid Treatment. withdrawal from metapproved for use in a specific process.	sible in handling opioid drugs. Involving a client with a disability, there is a maximum oses allowable in any two-weeks two years of continuous who is unable to conform to the ory schedule because of a disability may be permitted the eligibility by the State who are granted additional who due to a verifiable physical anted up to a maximum ke-home medication and shall a visits. The Dosages For Holidays: It is of methadone or other wed for the treatment of opioid authorized by the facility ividual client basis according and one-day supply of a medications approved for the addiction may be dispensed in the client at the emedications at Level 4 or medications at Level 4 or medications and benefits of ethadone or other medications opioid treatment shall be the client at the initiation of				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		MHL011-390	B. WING		07/1	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CEI	NTER FOR SPIRITUA	FIVIER GENCE &	TH LOUISIAN LE, NC 2880	NA AVENUE, SUITES D3 & D4 06		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERSON THE APPROPRIES OF	JLD BE	(X5) COMPLETE DATE
V 238	(h) Random Testin and other drugs shactive opioid treatmone random drug to treatment. Addition three-month period treatment episode, will be observed by to include at least to methadone, cocain amphetamines, The alcohol. Alcohol te by either urinalysis, alternate scientifical (i) Client Discharged be discharged from dependent upon mapproved for use in client is provided the drug. (j) Dual Enrollment outpatient opioid as which dispense Me Levo-Alpha-Acetyl-pharmacological as Drug Administration addiction subseque required to participate and discharge with all owithin at least a 75-program. Program participate in a common Management and Manageme	g. Random testing for alcohol all be conducted on each nent client with a minimum of est each month of continuous hally, in two out of each of a client's continuous at least one random drug test program staff. Drug testing is the following: opioids, e, barbiturates, C, benzodiazepines and sting results can be gathered breathalyzer or other ally valid method. Restrictions. No client shall a the facility while physically ethadone or other medications opioid treatment unless the e opportunity to detoxify from a Prevention. All licensed addiction treatment facilities thadone, Methadol (LAAM) or any other gent approved by the Food and a for the treatment of opioid ent to November 1, 1998, are ate in a computerized Central that clients are not dually of direct contact or a list pioid treatment programs emile radius of the admitting a realso required to aputerized Capacity Vaiting List Management hed by the North Carolina	V 238			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL011-390		B. WING		07/*	18/2018
	PROVIDER OR SUPPLIER	_ EMERGENCE &	370 NOR1		STATE, ZIP CODE NA AVENUE, SUITES D3 & D4 06	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 238	control plan as part shall document the procedures. A dive the following eleme (1) dual enrol that consist of clien program contacts, pregistry or list excha (2) call-in's for solid dosage forr (3) call-in's for (4) drug testil review of the levels medications approvaddiction; (5) client atte	h and maintain a diversity of program operation plan in their policies resion control plan shouts: Illment prevention met to consents, and either participation in the ceanges; or bottle checks, bottle checks, bottle checks, bottle of methadone or other of methadone or other ded for the treatment and ance minimums; as to ensure that clies	ns and and all include easures er entral e returns e a ner of opioid and	V 238			
	facility failed to ensiclients (Clients #1, #10, #11, #13 and #within a 75 miles ra Review on 7/17/18 -Admission date: 2/ -Diagnoses of Opio and High Blood Pre	views and interviews ure thirteen of thirteen #2, #3, #4, #5, #6, #7 #14) were not dually dius .The findings ar of client #1's record 28/17 id Use Disorder, Hepssure. of client #2's record 10/10/17	rn audited 7, #8, #9, enrolled e: revealed: patitis C				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	MHL011-390	B. WING		07/	18/2018	
NAME OF PROVIDER OR SUPPLIER THE CENTER FOR SPIRITUAL EME	RGENCE & 370 NOR	ADDRESS, CITY, STATE, ZIP CODE RTH LOUISIANA AVENUE, SUITES D3 & D4 LLE, NC 28806				
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE	
Review on 7/17/18 of clie -Admission date: 3/20/18 -Diagnosis of Opioid Use Review on 7/17/18 of clie -Admission date: 6/12/18 -Diagnosis of Opioid Use Review on 7/17/18 of clie -Admission date: 11/22/1 -Diagnoses of Opioid Use Disorder, Depression, An Post-Traumatic Stress Di Personality Disorder and Review on 7/17/18 of clie -Admission date: 6/28/18 -Diagnoses of Opioid Use Hypertension, Insulin Dep Hyperlipidemia and Gastra Review on 7/17/18 of clie -Admission date: 4/10/18 -Diagnoses of Opioid Use Depression. Review on 7/17/18 of clie -Admission date: 12/3/17 -Diagnosis of Opioid Use Review on 7/17/18 of clie -Admission date: 3/7/18 -Diagnosis of Opioid Use Review on 7/17/18 of Clie revealed: - Admission date of 1/2/1 -Diagnosis of Opioid Use Review on 7/17/18 of Clie revealed: - Admission date of 1/2/1 -Diagnosis of Opioid Use Review on 7/17/18 of Clie revealed: - Admission date of 1/2/1 -Diagnosis of Opioid Use	Disorder. nt #4's record revealed: Disorder. nt #5's record revealed: Disorder, Sedative Use xiety Disorder, Sorderline Agoraphobia. nt #6's record revealed: Disorder, Sedative Use xiety Disorder, Sorderline Agoraphobia. nt #6's record revealed: Disorder, Sedative Use xiety Disorder, Sorderline Agoraphobia. nt #6's record revealed: Disorder, Asthma and Sedate Disorder, Asthma and Sedate Disorder. nt #8's record revealed: Disorder. nt #9's record revealed: Disorder. ent #10's record 8. Disorder.	V 238				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED			
		MHL011-390		B. WING		07/	18/2018	
	PROVIDER OR SUPPLIER	_ EMERGENCE &	370 NOR1	ADDRESS, CITY, STATE, ZIP CODE RTH LOUISIANA AVENUE, SUITES D3 & D4 ILLE, NC 28806				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 238	revealed: - Admission date of -Diagnoses of Opio Hypertension. Review on 7/17/18 revealed: - Admission date of -Diagnosis of Opioi Review on 7/17/18 revealed: - Admission date of -Diagnosis of Opioi Deficit Hyperactivity Interview on 7/18/1 revealed: -It was the respons desk/administrative enrollment informat Unfortunately, staff not the sheet with the across it.	f 1/30/18. id Use Disorder and of Client #13's record f 2/27/18. d Use Disorder. of Client #14's record f 2/16/18. d Use Disorder and A / Disorder. 8 with the Program D ibility of the front f staff to fax new clien	d Attention Director nt et faxed,	V 238				
V 752	10A NCAC 27G .03 EQUIPMENT (b) Safety: Each fa constructed and eq ensures the physical visitors. (4) In areas constructed to hot water	ot Water Temperature 304 FACILITY DESIGN cility shall be designed uipped in a manner to al safety of clients, stall of the facility where contained between 100- to.	ed, hat aff and lients are of the	V 752				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL011-390	B. WING		07/1	8/2018
	PROVIDER OR SUPPLIER	STREET AD STREET AD 370 NOR	, ,	STATE, ZIP CODE NA AVENUE, SUITES D3 & D4 06	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 752	This Rule is not me Based on observatifailed to maintain the between 100 - 116 areas where clients findings are: Observation on 7/1 water temperature the hot water meast temperature was te 10:15AM in the client Degrees F. Interview on 7/18/13 revealed: -He had already spette "on-demand" ur		V 752			