UIVISION	of Health Service Re	egulation			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIERCLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL026-952	B. WING		R 02/06/2020
NAME OF	PROMDEROR SUPPLIER	STREET AL	DRESS, CITY, 5	STATE, ZIP CODE	
A 55 5 5 14	NOTES AAMA NOVE		MBERSBUR		
AURIEN	NE'S HOUSE		VILLE, NC 28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIETION OF CORRECTIVE APPROPRICTION OF CORRECTIVE ACTION O	DBE COMPLE
V 000	INITIAL COMMENT	rs	V 000		
	on February 6, 2020 unsubstantiated (int	low up survey was completed 0. The complaint was take #NC00160621).			
		sed for the following service C 27G .1700 Residential cure for Children or			
V 132	G.S. 131E-256(G) H Allegations, & Prote	HCPR-Notification,	V 132		
	REGISTRY (g) Health care facil Department is notifil health care personn unknown source, wi	ALTH CARE PERSONNEL ities shall ensure that the ed of all allegations against el, including injuries of nich appear to be related to division (a)(1) of this section.		RECEIVED	
4	facility or a person to as defined by G.S. 1 as defined by G.S. 1	e of a resident in a healthcare b whom home care services 131E-136 or hospice services 31E-201 are being provided.		FEB 2 8 2020 DHSR-MH Licensure Sect	T = U : v + v - v - v - v - v - v - v - v - v -
	in a health care facil (b) of this section ind care services as def	of the property of a resident ity, as defined insubsection cluding places where home ined by G.S. 131E-136 or defined by G.S. 131E-201			
	 Misappropriation healthcare facility. Diversion of drug 	gs belonging to a healthcare			Marya di Persana
	a patient or client for providing services). Facilities must have	t or client, health care facility or against whom the employee is evidence that all alleged I and must make every effort			
ion of Hea	olth Service Regulation >	NSUPPLIER PER RESENTATIVE'S SIGN	ATURE	TITLE Executive Director	(X6) DATE 02-27-2020

JSS411

Division	n of Health Service Re	gulation			FOR	M APPROVED
STATEME	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	TE SURVEY
	TO THE PROPERTY OF THE PROPERT	INCOTIFICATION NUMBER:	A. BUILD#	NG:		WPLETED
		MHL026-952	B. WING_		02	R /05/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	ODRESS, CIT	Y, STATE, ZIP CODE	Secretary of the Second Section Sectio	
ADRIEN	INE'S HOUSE	4528 CH	AMBERSBI	URG ROAD		
			EVILLE, NC	28314		
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF CHEMICY)	DAF	COMPLETE DATE
V 132	Continued From page	ge 1	V 132			
	investigation is in pr investigations must	ve working days of the initial				
∨ 367	facility failed to report the Health Care Pers findings are: Review on 02/06/20 documentation the Hallegation of abuse a Professional/License See Tag V367 for sp. Interview on 02/06/20 stated she understoo should be reported to 27G .0604 Incident R. 10A NCAC 27G .0 REPORTING REQUICATEGORY AAND E.	iews and interviews, the tan allegation of abuse to sonnel Registry (HCPR). The of facility records revealed no CPR was notified of an gainst the Qualified e. acifics. the Administrative Staff of all allegations against staff of the HCPR. deporting Requirements 1604 INCIDENT REMENTS FOR	∨ 367	HCPR was not initially submitted againe QP because it was revealed per consumer that the allegation was fals. This was admitted the same day duri therapy session. The HCPR was sub	the se. na his	02-10-2020

JSS411

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
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		MHL026-852	8. WING		R	
NAME OF	PROVIDER OR SUPPLIER	STORTEN			02/06/2020	
			MBERSBUR	STATE, ZIP CODE		
ADRIEN	NE'S HOUSE		VILLE, NC 26			
A 0 10	CHAMARY CTA	TEMENT OF DEFICIENCIES				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLE	
V 367	Continued From pa	ge 2	V 367			
	level II incidents, excithe provision of billar consumer is on the incidents and level I to whom the provide 90 days prior to the responsible for the consumer are provided becoming aware of the submitted on a formation. The report in person, facsimile means. The report information: (1) reporting prodentification information: (2) client identification information: (3) type of incident (4) description (5) status of the cause of the incident (6) other indiviror responding. (b) Category A and Emissing or incomplet shall submit an updare report recipients by the day whenever: (1) the provided erroneous, misleadin (2) the provided required on the incident canavallable. (c) Category A and B	cept deaths, that occur during the services or while the providers premises or level III I deaths involving the clients in rendered any service within incident to the LME catchment area where it within 72 hours of the incident. The report shall arm provided by the rimay be submitted via mail, or encrypted electronic hall include the following rovider contact and alion; incident; of incident; of incident; in the effort to determine the the and duals or authorities notified the end of the next business or has reason to believe that in the report may be go or otherwise unreliable; or robtains information ent form that was previously providers shall submit.	∨ 367			
	upon request by the I obtained regarding th	ME, other information is incident, including:	İ		T grande of the state of the st	
1	(1) hospital rec information;	ords including confidential			Westernament and the second	
ision of Hes	alth Service Regulation					

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A RIM DING		(X3) DATE SURVEY COMPLETED	
	Andrew Company		A. BUILDING:		
	MHL026-952	B. WING		R 02/06/2020	
NAME OF PROVIDEROR SUPPLIE	PTOECT AT	Parce any e		1 050082020	
		MBERSBUR	STATE, ZIP CODE		
ADRIENNE'S HOUSE		WILLE, NC 28			
The first parties of	The state of the s				
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V 367 Continued From page 3		V 367			
(2) reports to (3) the provided of all level III incided Mental Health, De Substance Abuse becoming aware of providers shall serincidents involving Health Service Respectation of a level (2) restrictive the definition of a level (2) restrictive the possession of (5) the total incidents have occurred any of the critical incidents have occurred any occurred any occurred any	by other authorities; and der's response to the incident. If B providers shall send a copy ent reports to the Division of velopmental Disabilities and Services within 72 hours of the incident. Category A and a copy of all level III a client death to the Division of gulation within 72 hours of the incident. In cases of seven days of use of seclusion ovider shall report the death quired by 10A NCAC26C AC 27E .0104(e)(18). If the LME responsible for the level services are provided, a submitted on a form provided a electronic means and shall information as follows: In errors that do not meet the lift or level III incident; interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in a client; number of level III and levelIII rred; and ent indicating that there have incidents whenever no urred during the quarter that teria as set forth in Paragraphs the and Subparagraphs (1)				
ion of Health Service Regulation					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER:	Division	of Health Service Re	agulation			FURN	APPROVED
MAME OF PROVIDEROR SUPPLIER ASSECTION STATE TO COMPLETED ASSECTION STATE TO COMPLETE STREET ADDRESS, CITY, STATE ZIP CODE 4528 CHAMBERSBURG ROAD FRETRY FAVETTEVILLE, NC 2814 (C4.1)0 REQUIATORYORLSCIDENTIFYINGINFORMATION V 367 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report a critical incident to the nome Local Management Entity (LME) as required. The findings are: Review on 02/06/20 of the "North Carolina Incident Response Improvement System ((RIS)" website for January 2020 thru present revealed no Level II incident reports for the facility had been generated. Review on 02/06/20 of a email from client #3's therapist dated 02/05/20 revealed: - "Client #3's initials verbalized left guilty for making false allegations against the Qualified Professional (QP)/Licensee. Review on 02/06/20 the QP/Licensee stated: - Client #3's had recently gotten suspended from school The Associate Professional (AP) had picked client #3 to the facility Client #3 began having a behavior and kicking the seat. The AP notified him and he met staff	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	LOCAL DAT	E GUDAEV
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~ Client #3 began having a behavior and kicking the seat. The AP notified him and he met staff	į	client #3 up from sci	nool and was transporting				
the seat. The AP notified him and he met staff		Client #2 homen has	y.				
and client at the facility		the seat The AD not	wing a periavior and kicking				ı
GROW MINISTER OF THE PARTIES.	į	and client at the facil	ity		(8)		
- He met client #3 at the corner of the house and						j	
held client #3 by the biceps area. He picked client						1	
#3 up off the ground to eye level briefly and	1 3	#3 up off the ground	to eye level briefly and			1	
discussed concerns with safety while riding in the		discussed concerns	with safety while riding in the			1	1
van.		van.		i		İ	- 1
- He put client #3 down close to a bush. The	1:	- He put client #3 do	wn close to a bush. The				l
incident was very brief. Client #3 was not injured.		incident was very brid	ef. Client #3 was not injured.			1	1
- A representative from the local Department of			om the local Department of		37		

AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY
		EME ORC DES	B. WING			R
	MHL026-952				02	/06/2020
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
DRIEN	NE'S HOUSE		AMBERSBUR EVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULDBE	(X5) COMPLI
V 367	Continued From pa	ige 5	V 367			-
	Social Services (D: abuse from the inci - Client #3 was not incident.	SS) had asked asked about dent. abused nor injured from the the therapist he lied about an				
	stated: - She had not comp #3's allegation agai - She understood at any staff needed to - She thought a DS	20 the Administrative Staff pleted an IRIS report forclient next the QP/Licensee. If allegations of abuse against be reported in IRIS. S representative had visited /20 to investigate client #3's				
V 537	and must be correct	estitutes a re-cited deficiency ted within 30 days.] ghts - Training in Sec Rest &	V 537			
	10A NCAC 27E .010 SECLUSION, PHYS ISOLATION TIME-C (a) Seclusion, phys time-out may be em been trained and ha competence in the p to these procedures staff authorized to e procedures are retra competence at least (b) Prior to providing disabilities whose to includes restrictive is service providers, es	D8 TRAINING IN SICAL RESTRAINT AND DUT ical restraint and isolation ployed only by staff who have ive demonstrated proper use of and alternatives reacilities shall ensure that imploy and terminate these ained and have demonstrated				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1		A. BLALDING:		COMPLETED
		MHL026-952	B. WING		R 02/96/2020
NAME OF	PROVIDEROR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ACDIEN	NE'S HOUSE		MBERSBUR		
AURGEN	NE 3 NOUSE		VILLE, NC 28		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		THE REPORT OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO	10	PROVIDER'S PLAN OF CORRECT	Au 1
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETE
V 537	Continued From pa	ge 6	V 537		
	seclusion, physical and shall not use the training is complete demonstrated. (c) A pre-requisite of demonstrating complete demonstrating complete demonstrating complete demonstrating complete in the need for restrict (d) The training shall include measurable testing of behavior) on those of methods to determine course. (e) Formal refreshed by each service programustly). (f) Content of the training of MH/D Paragraph (g) of this (g) Acceptable training but are not limited to (1) refresher in the use of restrictive (2) guidelines (understanding imminothers); (3) emphasis of rights and dignity of concepts of least resincremental steps in (4) strategies in (4) strategies of restrictive intervental steps in restrictive intervental steps in the concepts of restrict	restraint and isolation time-out ese interventions until the d and competence is for taking this training is petence by completion of g, reducing and eliminating ive interventions. Il be competency-based, learning objectives, (written and by observation of objectives and measurable ne passing or failing the rataining must be completed vider periodically (minimum aining that the service oploymust be approved by DD/SAS pursuant to grue, presentation of: information on alternatives to interventions; on when to intervene inent danger to self and on safety and respect for the all persons involved (using strictive interventions and an intervention); for the safe implementation interventions;			
1	(5) the use of a interventions which is	emergency safety			
		nitoring of the physical and			
		sing of the client and the safe			
	use of restraint throu	ghout the duration of the			1 1
i					
vasion of He	alth Service Regulation				1

Division of realin Service Regulation					APPROVED	
	NT OF DEPICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LÉ CONSTRUCTION	(X3) DAT	ESURVEY
AND PLA	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING			PLETED
						-
		MHL026-952	8. WNG			R 06/2020
HAME OF	PROVIDER OR SUPPLIER				024	06/2020
				STATE, ZIP CODE		
ADRIEN	NE'S HOUSE		MBERSBUF			
etraidre-id-minhidem-utver			VILLE, NC 2	8314		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTO	ON	Q(5)
TAG	REGULATORYORLS	SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES.)	DBE	COMPLETE
	100 Harris 11 Marie 100 Ma	, , , , , , , , , , , , , , , , , , , ,	170	DEFICIENCY)	ACBETE	DATE
V 537	Continued Communication				***	
V 301	Continued From pa	ge /	V 537			
	restrictive interventi					
		procedures;				
		strategies, including their				
	importance and pur	pose; and				
	(8) document	ation methods/procedures.				1
į	(h) Service provider		!			1
	documentation of in	itial and refresher training for	[
	at least three years.		-			
1		ation shall include:				
	(A) who partici	pated in the training and the	i			
	outcomes (pass/fail)		****			
	(B) when and (C) instructor's	where they attended; and				
						i
1		on of MH/DD/SAS may locumentation at any time.			Ì	
	(i) Instructor Qualific	oton and Training				1
	Requirements:	auditand framing				- 1
		nall demonstrate competence	1			
	by scoring 100% on	testing in a training program	į			1
i	aimed at preventing.	reducing and eliminating the				
	need for restrictive in		1		- 1	
i	(2) Trainers st	rall demonstrate competence	!		-	
	by scoring 100% on	testing in a training program	į		1	1
ļ	teaching the use of s	eclusion, physical restraint	,		-	1
	and isolation time-ou					
	(3) Trainers st	nall demonstrate competence	i		1	- 1
		grade on testing in an	Ì			1
	instructor training pro	ogram.	-		1	
	(4) The training				1	1
	competency-based,	include measurable learning	1		-	
	objectives, measural	ole testing (written and by				- 1
ĺ	observation of behav	rior) on those objectives and			ĺ	1
		to determine passing or				
	failing the course.	4 = £ 4b = i = -4 = -4 = -5 = -5	!			I
	(5) The conten	t of the instructor training the	į			1
	service provider plan	s to employ shall be				
		sion of MH/DD/SAS pursuant	-			
	to Subparagraph (j)(6 (6) Acceptable	instructor training programs	1			- 1
1	(~) uccelulanie	manufacture semined brodustus	!			ł
rision of Hea	alth Service Regulation					

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
			B. WING			R
] #MLT056-825		MHL026-952	B. WING		02	06/2020
IAME OF	PROVIDER OR SUPPLIER		DORESS, CITY, 8			
UDRIEN	KE'S HOUSE		ambersbur(Eville, NC 28:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPLE COMPLE DATE
V 537	Continued From pa	ge 8	V 537			
	shall include, but no	ot be limited to, presentation				
	7.11	ding the adult learner,				
		for teaching content of the	1			
	course;					
1		n of trainee performance; and				1
ı		ation procedures.				
	• •	shall be retrained at least				
-		nstrate competence in the use al restraint and isolation				1
1		ed in Paragraph (a) of this	1			
Ì	Rule.	and the first firs				:
	(8) Trainers shall be currently trained in CPR.		The state of the s			
- 1		half have coached experience				
	in teaching the use	of restrictive interventions at				
	coach.	a positive review by the				
		hall teach a program on the erventions at least once				
1		hati complete a refresher				
	instructor training at	least every two years.				1
1	(k) Service provider	s shall maintain				
1		itial and refresher instructor				
ĺ	training for at least (hree years. lation shall include:				
		ipated in the training and the	-			
	outcome (pass/fail);					
1	(B) when and	where they attended; and				
(C) instructor's name.						
	(2) The Division of MH/DD/SAS may		l i			
		documentation at any time.	!			
	(I) Qualifications of (1) Coaches s	Coacnes: shall meet all preparation				!
	requirements as a tr					:
		shell teach at least three				
		hich is being coached.				
		shall demonstrate				
			. 1			1

	of Health Service Re	egulation			. 01/14	ALLKOAED
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:		E SURVEY PLETED
	-	MHL026-952	B. WING		The second of th	R 06/2020
NAME OF	PROVIDEROR SUPPLIER	STREET AC	DRESS, CITY	, STATE, ZIP CODE		
ADRIEN	NE'S HOUSE	4528 CHA	WIBERSBU VILLE, NC	RG ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 9	V 537			
		npletion of coaching or ruction. shall be the same				
	facility failed to ensu (Qualified Professio	views and interview, the ure one of three audited staff nal (QP)/Licensee) setence in the proper use of		The Administrator will ensure that all members will not utilize any other more restraints besides the current star approved techniques as demonstrate certified instructors.	ethods te	02-10-2020
	revealed: - 13 year old male Admission date of - Diagnoses of Atter Disorder, Opposition	of client #3's record 10/11/19, Ition Deficit Hyperactivity nat Defiant Disorder, sive Disorder and Specific				
	incident Response I website for January	of the "North Carolina mprovement System (IRIS)" 2020 thru present revealed reports for the facility had				
	documented Level II generated for client against the Qualified	of facility records revealed no incident reports had been #3's allegation of abuse Professional (QP)/Licensee.				
	personnel record rev - Date of hire: 02/02/	01. rvention Plustraining				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY		
,		IDENTIFICATION NOTEDERS.	A BUILDING	3:	COMP	LETED
	T-4-1	MHL026-952	B. WING		02/0	8/2020
NAME OF	PROVIDEROR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE		
ADDIEN	NE'S HOUSE		MBERSOU			
	TO THOUSE	FAYETTE	VILLE, NC :	28314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPRODEFICIENCY)	ADBE	COMPLETE DATE
V 537 Continued From page 10 Interview on 02/06/20 the QP/Licensee stated: - Client #3 had recently gotten suspended from school.		V 537	The state of the s			
	son of Health Sender Paradistion					



P.O. Box 25112 . Fayetteville, NC 28314

Phone: (910) 826-2273 . Fax: (910) 483-9600

Keeping the focus on you

Working Hand In Hand With The Community

Facsimile Transmittal

To: Tonya Bridges	Fax: 919 - 715 - 8078
From: T. Maxwell	Date: 2.28.2020
Re: 216:2020 POC	Pages: 12_
CC:	
☐ Urgent ☐ For Review ☐ Please	Comment ☐ Please Reply ☐ Recycle

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