

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2020
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G140 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/14/2020 |
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| NAME OF PROVIDER OR SUPPLIER STEM ROAD HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 702 STEM ROAD CREEDMOOR, NC 27522 |
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| (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) COMPLETION DATE |
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| W 120 | <p>SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3)</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure outside services met the needs of 1 of 4 audit client (#6). Specifically the behavior support plan (BSP) was not shared with the school. The finding is:</p> <p>Client #6's BSP; relevant emerging behaviors or other important information was not provided to the school.</p> <p>Interview on 1/13/20 with 3 high school teachers revealed no behavior support plan or individual program plan (IPP) was provided to them this year. Furthermore, all teachers interviewed indicated they are not confident that the home shares information that may be relevant with them. For example, the school indicated sometimes a bruise appears on a child and they have no idea if the home has seen the bruise or if they have not. The teachers indicated that while they invited the home to the individual education program (IP) meetings, they have not been invited to the homes individual program plan (IPP) meetings. Further interview on 1/13/20 revealed the school has no knowledge of any emerging sexual behaviors and that client #6 walks independently between classes and to the bathroom.</p> <p>Interview on 1/13/20 with the qualified intellectual disabilities professional (QIDP) revealed that he</p> | W 120 | <p>The Administrator will in-service the QIDP on the importance of sharing information with the school, providing current PCP, BSP and discussing any changes in target behaviors or medical conditions in order to meet client needs in all settings. The Administrator will meet with school representatives to clarify notifications expectations and to provide his contact information if school has question, issues, or concerns they would like to discuss. The Administrator will monitor PCP's, BSP and Incident Reports to ensure the schools have been notified of important information. In the future the QIDP will ensure all emerging behaviors and relevant information is provided to the school to meet client needs.</p> <p style="text-align: center;">RECEIVED FEB 04 2020 DHSR-MH Licensure Sect</p> <p style="text-align: right;"><i>[Signature]</i> TITLE 02/03/20 (X5) DATE</p> | 3/14/20 |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

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| W 120 | Continued From page 1 felt he provided sufficient information to the school but he confirmed he had not provided a BSP or IPP this year. He further confirmed that he had not told the school about the incident of finding client #6 naked with a peer and the information client #6 gave them about what sexually he was trying to do to his peer. | W 120 | | |
| W 153 | STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure all officials were notified immediately of an incident. This potentially affected 1 of 4 audit client (#5). The finding is: The facility failed to notify the law enforcement agency and health care personnel of an incident of potential sexual abuse During a review of client #5's record on 1/13/20, a core team dated 8/12/19 revealed "inappropriate sexual contact with a peer." The core team noted an increase in monitoring but not any more details. Review of the facility investigation revealed client #5 was "missing" so a search of the home was conducted. At that time, client #6's door was | W 153 | The Regional Vice President will in-service the Administrator and QIDP's on reporting procedures, Investigating allegations of abuse, neglect, exploitation, and injuries of un-know origin. The Administrator will monitor all incidents as they occur to determine if an investigation is warranted, the appropriate reporting notifications needed, and to ensure completion. In the future the Administrator will ensure all allegations of mistreatment, neglect, or abuse as well as injuries of unknown origin are investigated thoroughly and reported in accordance of state law. | 3/14/20 |

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| W 153 | Continued From page 2 found to be locked. The staff obtained a key to unlock it. The staff statement revealed before the staff could put the key in the door to unlock it client #5 opened client #6's door. The report indicated client #6 stated he penetrated client #5 in his behind and then he said he "tried" but did not. He was taken to the hospital but no IRIS report including notification of law enforcement was found. There was no discussion of notification of the school. Interview with the facility qualified intellectual disability professional (QIDP) on 1/14/20 confirmed that the IRIS with law enforcement notification could not be located. He further indicated that the school notification had been discussed but not documented and they opted not to inform the school. The psychologist confirmed this. | W 153 | | |
| W 154 | STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure a thorough investigation of all incidents and elopements. This potentially affected all clients residing in the facility. The finding is: Two (2) incidents (one of elopement and one of a possible sexual encounter) were not thoroughly investigated by the facility. During a review of client #5's record on 1/13/20, a | W 154 | The Regional Vice President will in-service the Administrator and QIDP's on reporting procedures, Investigating allegations of abuse, neglect, exploitation, and injuries of un-know origin. The Administrator will monitor all incidents as they occur to determine if an investigation is warranted, the appropriate reporting notifications needed, and to ensure completion. In the future the Administrator will ensure all allegations of mistreatment, neglect, or abuse as well as injuries of unknown origin are investigated thoroughly and reported in accordance of state law. | 3/14/20 |

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| W 154 | <p>Continued From page 3</p> <p>core team meeting dated 7/9/19 revealed an elopement /AWOL had occurred. The team meeting also noted that 15 minute checks would be added to his program as well as alarms added to his windows and modifications made to the back fence. However, the core team did not indicate where he eloped to; how long he was gone; where staff was when it happened etc.</p> <p>Interview with management on 1/13/20 confirmed client #5's elopement happened but was not investigated.</p> <p>During further review of client #5's record on 1/13/20, a core team dated 8/12/19 revealed "inappropriate sexual contact with a peer." The core team noted an increase in monitoring but not any more details.</p> <p>Review of the facility investigation revealed client #5 was "missing" so a search of the home was conducted. At that time, client #5's door was found to be locked. The staff obtained a key to unlock it. The staff statement revealed before the staff could put the key in the door to unlock it, client #5 opened client #6's door. The report indicated client #6 stated he penetrated client #5 in his behind and then he said he "tried" but did not. He was taken to the hospital but no IRIS report including notification of law enforcement was found. There was no discussion of notification of the school. The recommendation was for the psychologist to remove "M" games from client #5's collection.</p> <p>Further interview with the facility QIDP on 1/14/20 confirmed that the IRIS with law enforcement notification could not be located. He further indicated that the school notification had been</p> | W 154 | | |
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| W 154 | Continued From page 4 discussed but not documented and they opted not to inform the school. The psychologist confirmed this. The QIDP confirmed without the notifications and discussion the investigation is not thorough. The inappropriate sexual behavior was added to a BSP. Further interview with the QIDP on 1/14/20 confirmed the elopement(s) were never investigated. The psychologist confirmed this behavior remains addressed by a behavior support plan. | W 154 | | |
| W 156 | STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure all officials were notified within five working days of an incident. This potentially affected 1 of 4 audit client (#5). The finding is: The facility failed to notify the law enforcement agency and health care personnel of an incident of potential sexual abuse During a review of client #5's record on 1/13/20, a core team dated 8/12/19 revealed "Inappropriate sexual contact with a peer." The core team noted an increase in monitoring but not any more details. | W 156 | The Regional Vice President will in-service the Administrator and QIDP's on reporting procedures, Investigating allegations of abuse, neglect, exploitation, and injuries of un-know origin. The Administrator will monitor all incidents as they occur to determine if an investigation is warranted, the appropriate reporting notifications needed, and to ensure completion. In the future the Administrator will ensure all allegations of mistreatment, neglect, or abuse as well as injuries of unknown origin are investigated thoroughly and reported in accordance of state law. | 3/14/20 |

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| W 156 | <p>Continued From page 5</p> <p>Review of the facility investigation revealed client #5 was "missing" so a search of the home was conducted. At that time, client #6's door was found to be locked. The staff obtained a key to unlock it. The staff statement revealed before the staff could put the key in the door to unlock it client #5 opened client #6's door. The report indicated client #6 stated he penetrated client #5 in his behind and then he said he "tried" but did not. He was taken to the hospital but no IRIS report including notification of law enforcement was found. There was no discussion of notification of the school.</p> <p>Interview with the facility qualified intellectual disability professional (QIDP) on 1/14/20 confirmed that the IRIS with law enforcement notification could not be located. He further indicated that the school notification had been discussed but not documented and they opted not to inform the school. The psychologist confirmed this.</p> | W 156 | | |
| W 159 | <p>QIDP CFR(s): 483.430(a)</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the qualified intellectual disability professional (QIDP) coordinated, integrated and monitored the active treatment program for 1 of 4 audit clients (#6). The finding is:</p> <p>The QIDP did not assure the school knew about an incident of sexually inappropriate behavior and provide a copy of the behavior support program</p> | W 159 | | |

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| W 159 | <p>Continued From page 6 (BSP).</p> <p>During a review of client #5's record on 1/13/20, a core team dated 8/12/19 revealed "inappropriate sexual contact with a peer." The core team noted an increase in monitoring but not any more details.</p> <p>Review of the facility investigation revealed client #5 was "missing" so a search of the home was conducted. At that time, client #6's door was found to be locked. The staff obtained a key to unlock it. The staff statement revealed before the staff could put the key in the door to unlock it client #5 opened client #6's door. The report indicated client #6 stated he penetrated client #5 in his behind and then he said he "tried" but did not. He was taken to the hospital but no IRIS report including notification of law enforcement was found. There was no discussion of notification of the school.</p> <p>Interview with the facility qualified intellectual disability professional (QIDP) on 1/14/20 confirmed that the IRIS with law enforcement notification could not be located. He further indicated that the school notification had been discussed among management but they did not want to notify the school and the discussion was not documented. The psychologist confirmed this. However, the inappropriate sexual behavior was added to a BSP.</p> <p>Interview with the school on 1/14/20 revealed the teachers had not been provided with copies of the BSP. Furthermore, the teacher for client #5 revealed she was not aware of any inappropriate sexual behaviors or emerging sexual behaviors. She was not aware of client #5 ever attempting to</p> | W 159 | <p>The Administrator will in-service the QIDP on the importance of sharing information with the school, providing current PCP, BSP and discussing any changes in target behaviors or medical conditions in order to meet client needs in all settings. The Administrator will meet with school representatives to clarify notifications expectations and to provide his contact information if school has question, issues, or concerns they would like to discuss. The Administrator will monitor PCP's, BSP and Incident Reports to ensure the schools have been notified of important information. In the future the QIDP will ensure all emerging behaviors and relevant information is provided to the school to meet client needs.</p> | 3/14/20 |
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| W 159 | Continued From page 7 touch anyone inappropriately. She stated she hoped the home management would notify the school of any such emerging behaviors. She also indicated client #5 is not monitored at all times and he is independent at walking to classes and to the bathroom. | W 159 | | |
| W 369 | <p>DRUG ADMINISTRATION CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all medications were given as ordered. This affected 1 of 4 audit clients (#5). The finding is:</p> <p>One medication was not given at the dose it was ordered.</p> <p>During observations of the medication pass on 1/14/20 at 5:50am, client #5 was given Topamax 50 mg among other medications.</p> <p>After the observation on 1/14/20, the physician's orders signed 1/7/20 revealed, "Topamax 25 mg, Take 1 tablet by mouth twice a day 6:30 am."</p> <p>Interview with the nurse via phone on 1/14/20 revealed that the wrong order must be in the record. However, the QIDP confirmed there is no current order for Topamax 50 mg in the record.</p> <p>Note: After the survey the nurse revealed a fax copy of an order for Topamax 50 mg but the date</p> | W 369 | <p>The RN will in-service the nurses to ensure all physician orders are in chart and correspond with Medication Administration Orders. The RN will in-service staff on administering medications per the physician order. The clinical team will monitor through Medication Observations Assessments two times a week for one month and then on a routine basis to ensure staff are administering medications per the physician orders without error, and following Medication Administration Protocol. In the future the RN will ensure physician orders are in charts and staff are trained and administer all medications in compliance with the physician orders without error.</p> | 3/14/20 |

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| W 369 W 418 | <p>Continued From page 8 is not legible but appears to be 1/7/19 (not 2020). CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii)</p> <p>The facility must provide each client with a clean, comfortable mattress.</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility did not provide 1 of 4 audit clients (#4) a mattress, in good condition. The finding is: Client #4's mattress was lopsided.</p> <p>During observations in the home on 1/13/20 and 1/14/20, client #4's mattress had a noticeable upward tilt at the bottom of the bed.</p> <p>An interview with Staff E on 1/14/20 revealed that client #4 had needed several mattresses replaced over the years because client would jump up and down on the bed like a trampoline.</p> <p>During a conversation with the qualified intellectual disabilities professional (QIDP) on 1/14/20, regarding the condition of client #4's mattress, he offered no explanation if anyone monitored the conditions of furnishings.</p> | W 369 W 418 | <p>The Home Manager will exam all people supported mattresses to assess the new for replacement. The Home Manager or QIDP will completed monthly Environmental Assessment which will include inspections of all mattresses. The Home Manger will put in a request to replace mattresses when needed and give to Administrator for prompt replacement. In the future the QIDP will ensure all clients have a clean comfortable mattress.</p> | 3/14/20 |
| W 436 | <p>SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> | W 436 | | |

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| W 436 | <p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to furnish eyeglasses for 1 of 4 audit clients (#3). The finding is:</p> <p>Client #3 was prescribed single lenses eyeglasses.</p> <p>During observations in the home and at school, on 1/13/20-1/14/20, client #3 did not wear eyeglasses.</p> <p>During review on 1/13/20 of a vision exam dated 12/17/19, it was noted that client #3 was prescribed glasses, to "make things clearer." Client #3 did not need to wear the glasses full time.</p> <p>An additional review on 1/14/20 revealed that client #3's individual program plan (IPP) dated 12/30/19 had implemented a training goal on 1/9/20 to help client tolerate wearing his eyeglasses, with a graduated wear schedule. It was noted that the program would start, once client #3 received his eyeglasses.</p> <p>During an interview with the qualified intellectual disabilities professional (QIDP) on 1/14/20 he stated that client #3 was not taken to get eyeglasses yet because they had to get his Medicaid squared away, due to him using multiple names.</p> | W 436 | <p>The Administrator will in-service the QIDP, nursing, and Home Manager on the prompt purchase of any devices needed for clients identified by the team. The QIDP will monitor to ensure any devices prescribed are obtained timely though purchase requests sent to the Administrator. In the future the QIDP will ensure any devices identified by the interdisciplinary team are obtained timely.</p> | 3/14/20 |
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| W 460 | FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) | W 460 | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2020
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G140 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/14/2020 |
|--|--|--|--|

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|--|---|
| NAME OF PROVIDER OR SUPPLIER STEM ROAD HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 702 STEM ROAD CREEDMOOR, NC 27522 |
|--|---|

| (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) | (X6) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
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| W 460 | <p>Continued From page 10</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide the proper diet consistency for 3 of 4 audit clients (#1, #3 and #5). The findings are:</p> <p>1. Clients #1 and #3 food was not cut up into bite size pieces.</p> <p>a. During observations in the home on 1/13/20 at 5:15 pm, Client #1 was served chunky pieces of beef tips with gravy and cooked carrot slices, the size of quarters. The food was not cut into 1/2 inch pieces before consumed.</p> <p>Review on 1/13/20 of Client #1's individual program plan (IPP) dated 5/15/19 revealed that he was on a regular diet with 1/2 inch bite size pieces.</p> <p>b. During observations in the home on 1/13/20 at 5:15 pm, Client #3 was served chunky pieces of beef tips with gravy and cooked carrot slices, the size of quarters. The food was not cut into 1/4th of an inch pieces before consumed.</p> <p>Review on 1/13/20 of Client #3's individual program plan (IPP) dated 12/30/19 revealed that he was on a regular diet with 1/4th of an inch bite size pieces.</p> <p>During an interview on 1/14/20 with the qualified intellectual disabilities professional (QIDP), confirmed clients # 1 should have a cut diet (1/2</p> | W 460 | <p>The nurse will in-service staff on all client specific diets per the physician orders. The clinical team will monitor to ensure diet consistencies are follow as prescribed through Meal Time Assessments completed two times a week for one month and then on a routine basis. In the future the QIDP will ensure staff are trained and implement client specific diets as prescribed in the physician orders.</p> | 3/14/20 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2020
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G140 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/14/2020 |
|--|--|--|--|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER STEM ROAD HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 702 STEM ROAD CREEDMOOR, NC 27522 |
|--|---|

| (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) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| W 460 | <p>Continued From page 11 inch pieces.) and client #3 should have a cut diet (1/4 inch pieces).</p> <p>2. Client #5's food was not consistently cut into 1/2 bite size pieces.</p> <p>Observations of dinner on 1/14/20, revealed that client #5 had large round cuts of carrots and large pieces of beef. He ended up making a beef sandwich. Additionally, at breakfast he had whole toast, eggs and strips of bacon and began eating without any assistance in cutting his food items.</p> <p>Interview with the QIDP on 1/14/20 confirmed client #5 should have a cut diet (1/2 inch pieces.)</p> | W 460 | | |



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FAX TRANSMISSION

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

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| To: | <i>Eggar Moore</i> MHLCO | Fax: | 919 715-4078 |
| From: | <i>Perry Skinner</i> Skinner | Date: | 2/20/20 |
| Re: | <i>Plan of correction</i> | Pages: | (Including Cover) |
| CC: | | | 13 |
| Urgent | For Review | <u>As Requested</u> | Please Reply |
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