STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(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
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete health care registry checks on one (1) of four (4) sampled nursing assistants. Nurse Aide #2. The findings are: The facility policy for screening potential employees, last modified 3/11/04, included the procedure to obtain "A verification of the current license or certification status, including the Nurses Aide Registry will be obtained to include whether any disciplinary action has been taken against them." Review of employee files revealed Nurse Aide #2 began employment on 5/22/12. There was no evidence in the file that the nurse aide registry had been checked to ensure there were no findings of abuse against her. On 8/9/12 at 9:03 AM, the Administrator stated the Director of Nursing (DON) checked the nurse aide registry on all potential employees. On 8/9/12 at 4:14 PM, the DON stated that she checked the registry on all employees prior to	F 226	F 226 Corrective action for the alleged deficient Practice was accomplished by obtaining the Nurse Aid registry check for Nurse Aid # 2. A copy was placed in the personnel file of Nurse Aid #2 and a copy was placed in a file in the DON office. To ensure that others are not affected by the Same alleged deficient practice The Administrator in serviced all managers On the procedure and all personnel Files were audited to ensure that a copy of The registry check was included in each file. The system put into place to ensure that All employees files include a copy of the Registry check prior to hiring an employee Includes the use of a screening tool. The tool Will be used by the DON and the Administrator And will include the review of the registry check,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Long — TITLE: Administrator — (X6) DATE: 8/31/12

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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F 226	Continued From page 1 hire. She stated she made two copies of the registry; one was placed in the employee file and the other she kept in a notebook in her office. The DON stated she could not locate either copy for NA #2.	F 226	Agreement with the finding as related to offering A job, and ensures that a copy is present in the New hires personnel file. The tool will be completed For all existing employees and all new hires prior to	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide the care planned and physician ordered interventions to prevent significant weight loss for one of three sampled residents. Resident #13. The findings are: Resident #13 was admitted with diagnoses of failure to thrive, malnutrition, severe rheumatoid arthritis, history of cerebral vascular accident with left sided hemiparesis, depression and dementia. The significant change assessment dated 4/2/12 coded her with long and short term memory impairment and severely impaired decision making skills. Resident #13 weighed 104 pounds, required limited assistance with eating and received a mechanically altered diet.	F 309	The first day of employment. Audit findings will be reported Monthly to QA&A To ensure that this system remains in effect The Administrator will audit all new hire files Monthly until substantial compliance is achieved And 6 months thereafter. The administrator will Use the tool to audit all existing personnel records. Any issues will be addressed immediately. A report will be prepared for QA of all findings for Six months after substantial compliance is obtained. Completion 9/06/2012 F309 Corrective action for the alleged deficient Practice was accomplished by reviewing Residents # 13 current orders and comparing The tray card with the orders the OT	

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F 309	Continued From page 2 The Care Area Assessment dated 4/6/12 assessed her intake averaging 26 to 100 percent which was usual for her. Her weight was noted as stable and no care plan would be developed. The monthly weight tracker noted Resident #13's May 2012 weight was 101 pounds and the June 2012 weight was 95 pounds. In addition to the physician orders that included a mechanical soft diet with super foods, whole milk and ice cream at every meal and may have a sandwich at lunch (all in place since 2009), on 6/12/12 a peanut butter and jelly sandwich was ordered as an afternoon snack and weekly weights were started. On 6/12/12 a care plan addressing significant weight loss was initiated with a goal to have no further significant weight loss. Interventions included provide diet as ordered, provide super foods and snacks as ordered, monitor and record intake, monitor weekly and monthly weights and honor preferences as able. On 6/18/12 the physician ordered Remeron 15 mg at bedtime as an appetite stimulant. The quarterly nutrition assessment included a notation dated 7/6/12 by the registered dietician (RD) that Resident #13 weighed 94 pounds which demonstrated a significant loss of 5.9% in 30 days, 8.2% in 90 days and 10.6% in 180 days. The RD noted in part "weight loss deemed involuntary and not desired, however, anticipated r/t (related to) d/c (discontinuation) of po (by mouth) supplements r/t resident refusal to accept...diet order (and) meal pattern remain appropriate."	F 309	In serviced the nursing staff on 8/27/2012 pertaining to following physician ordered interventions, adaptive equipment, and resident # 13 individualized approaches. Resident # 13 tray is checked and tray card initialed per meal by a dietary designee to ensure that all items are available and prepared according to specifications. To ensure that others are not affected by the same Alleged deficient Practice all tray cards were audited For accuracy. All meals where monitored by the DON and Administrator on 8/31/12 . The current diet orders were compared to the tray cards. All snack orders were reviewed and the DON and Administrator or designee checked all snacks for accuracy on 8/30/12 To ensure that the facility remains in compliance A system of giving the DON in addition to the dietary Manager a copy of the diet communicator when Changes or new orders received. The dietary manager	

'ARTMENT OF HEALTH AND HUMAN SERVICES
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309	Continued From page 3 Per the monthly weight tracker, Resident #13 weighed 92 pounds in July 2012. On 7/20/12 the physician ordered a bedtime snack. Resident #13 was documented as weighing 88 pounds 8/6/12 per weekly weight documentation. On 8/7/12 at 12:22 PM, Resident #13's lunch tray was delivered. Resident #13 received the mashed potatoes (super foods) but did not receive whole milk or ice cream with the tray. The tray card included mechanical soft diet with super foods, ice cream and whole milk. On 8/7/12 at 3:02 PM snacks were delivered to the nursing station. A sandwich was provided for Resident #13. AT 3:06 PM, Resident #13 was asleep in bed. At 3:38 PM, Licensed Nurse #1, who passed out the snack, stated Resident #13 would not wake up for her snack and the nurse returned it to the kitchen. On 8/7/12 at 4:00 PM, Resident #13 was observed up in her wheelchair and a nurse aide was assisting her with a drink of water. She then was wheeled into the dining room where she sat until 5:42 PM when dinner was served. Resident #13's tray did not include the whole milk or ice cream. At 5:50 PM, the Dietary Manager offered no explanation for the missing ice cream and milk. On 8/8/12 at 9:29 AM, the Administrator stated the staff who delivered the trays should be checking the tray card at the time of service to ensure accuracy. On 8/8/12 at 9:40 AM the Dietary Manager (DM)	F 309	Will place the change on a diet board to be reviewed and initialed by all dietary workers. The dietary manager Will then issue an audit tool for the change To be completed by the cook and verified By the dietary manager each meal for two days After the change until substantial compliance is achieved The dietary and nursing staff were in serviced on the system On 8/30/2012, 09/02/2012.) order to ensure that the system remains in place and is effective. The DON or Social Worker will periodically interview residents or monitor trays with dietary changes, for accuracy. Interviews will be conducted weekly a report will be compiled monthly for QA The DON or QA designees will compile a report of the findings and a report from all audit tools will be reviewed weekly until substantial compliance is achieved then monthly thereafter for six month s during QA&A Audit findings will be reported Monthly to QA&A Completion 9/06/12	

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F 309	Continued From page 4 and Corporate Manager stated the tray cards were not set up correctly. The food items should have been listed in the middle of the tray card and not at the bottom of the tray card with the adaptive equipment. The DM stated there was a new dietary aide yesterday and missed putting the ice cream and milk on Resident #13's trays. On 8/8/12 at 12:35 PM a second tray was delivered to Resident #13 as the first tray did not include the divided plate. This second tray did not include the mashed potatoes which was the super foods. Interview with the cook on 8/8/12 at 12:50 PM revealed she just forgot the mashed potatoes on the second tray. At 12:51 PM the DM stated that this meal was the residents' monthly choice meal and there was a lot of extra foods listed on the tray card. The DM stated it was busy and they missed putting the mashed potatoes (super foods) on the second plate. Interview with Nurse Aide (NA)#4 on 8/8/12 at 2:20 PM revealed the ice cream and milk are used to make a milkshake for Resident #13. On 8/8/12 at 3:23 PM, afternoon snacks arrived at the nursing station. A half of a sandwich was labeled for Resident #13. This was delivered to Resident #13 by LN #1 who confirmed it was half a sandwich. On 8/8/12 at 4:00 PM interview with the DM and Corporate DM revealed Resident #13 should have received a full sandwich. On 8/9/12 at 4:16 PM interview with the DON revealed staff are expected to look at tray card for proper diet and obtain the correct diet if	F 309		

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F 309	Continued From page 6 necessary.	F 309		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide adaptive equipment for one (1) of one (1) sampled resident to promote independent feeding. The findings are: Resident #13 was admitted with diagnoses of failure to thrive, malnutrition, severe rheumatoid arthritis, history of cerebral vascular accident with left side hemiparesis, depression and dementia. A physician's order dated 3/24/10 instructed "Dietary to please put paper cup on tray for milk shakes to be mixed in for Resident to drink out of - Regular cup resident can not hold regular cup." Another physician's order dated 3/26/10 stated "send small styrofoam cups c (with) all meal trays." A notation on this order form under indication included that the resident liked and she could hold. The significant change assessment dated 4/2/12 coded her with long and short term memory impairment and severely impaired decision making skills. She was coded as having moderately impaired vision. Resident #13 weighed 104 pounds, required limited assistance	F 369	F369 Corrective action for the alleged deficient practice For resident # 13 was accomplished by reviewing Physician Orders, care plans and assessments to ensure that the interventions were appropriate. The Styrofoam Cup was discontinued and replaced by an order to provide cups with handles for all beverages. A referral was made for Resident # 13 to be screened and treated by Occupational Therapy. Occupational Therapy has worked on positioning, and adaptive equipment. Orders have been obtained for shallow bowls, t handle d cups, adaptive spoon, and puree diet. Other approaches indicated are: regular plate, and tablemate compatibility. Nursing staff was trained on approaches used to Ensure that resident #13 receives appropriate devices And interventions while maintaining her Independance.	

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F 369	Continued From page 6 with eating and received a mechanically altered diet. The dietary significant change assessment dated 4/2/12 indicated Resident #13 used a 3 compartment plate. The Care Area Assessment (CAA) dated 4/5/12 for vision indicated Resident #13 was able to identify objects but could not read find print and staff anticipated all needs. The CAA dated 4/5/12 for cognitive loss stated Resident #13 was not always understood and had limited ability to make needs known. The nutrition CAA dated 4/5/12 noted her intake varied from 25 to 100 percent which was usual for her. The quarterly nutrition assessment dated 7/2/12 indicated Resident #13 used a 3 compartment plate, ate 25 to 75% of her meals, 'feeds self slowly-needs extensive assistance.' The care plan, updated 7/5/12, for activities of daily living skills (ADLs) due to severe arthritis and dementia included the goal to have all adl needs met and to maintain current abilities. The care plan included the intervention "6. Eating: Assist as needed. Set up (open cartons, open straw, etc.) Encourage resident to feed self as much as possible. Uses Styrofoam cups/cups with handles to assist in independent intake d/t (due to) her dx (diagnosis) severe arthritis." Current computerized monthly physician orders included the orders for mechanical soft with super foods, whole milk and ice cream with all meals, small styrofoam cups and plastic cups with all meals.	F 369	To ensure that others are not affected by the same alleged deficient practice all charts were audited and a copy of the physicians orders pertaining to assistive devices and diets were compared to a copy of the diet cards for each meal as well as snack cards for each snack. each resident was monitored to see if any resident appeared to need a referral to OT for assistance with meals. The nursing staff and dietary staff were in serviced on interventions, diets and assistive devices and the procedure for ensuring that all orders were communicated and noted on the chart and tray cards. Nurses were in serviced on transferring telephone orders at the end of the month to ensure that orders not captured on the previous MAR are transcribed on the physician orders. To ensure that the system remains in place	

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F 369	Continued From page 7 Review of the weekly weight tracking form revealed Resident #13 weighed 88 pounds on 8/8/12. (13 pound / 7.7 percent weight loss in 3 months). Resident #13 was observed on 8/7/12 at 11:42 AM sitting at the dining room table waiting for lunch. Her right hand was very deformed (fingers curved to the right) with rheumatoid arthritis. The tray as delivered at 12:22 PM. The food came on a 3 compartment plate and she had a hard wide plastic cup with a lid and a straw filled with tea and a small packaged container of juice. She also used a regular spoon for the food. At 12:27 PM the administrator offered and provided her another wide plastic cup for the orange juice with a straw and a lid. Resident #13 was observed tipping the hard plastic cup over in order to access the straw. She was observed to have limited mobility in her right hand, her left was not used at all. She picked up the spoon with her thumb and first finger. She moved items around, i.e. the tray and cups with her first finger. At 1:17 PM she had eaten 25 % and had food spillage on her face and clothing protector. At no time did she have small plastic cups, cups with handles or styrofoam cups provided to her. On 8/7/12 at 5:42 PM, NA #1 delivered Resident #13 her evening tray. Resident #13 received her liquids in the wide hard plastic cups with lids and straws. No cups with handles were provided. She did not get her food in a 3 compartment plated and did not receive any styrofoam cups. The MDS nurse noted the missing 3 compartment plate and lack of styrofoam cups and proceeded to obtain these items form the	F 369	Is in place to ensure that compliance is maintained the dining designee will complete an audit tool each meal until substantial compliance is achieved then weekly for three months and monthly thereafter for 6 months. The tool will include all tray card orders and A visual check of compliance with the order as Compared to the items being delivered during Dining services. The completed tools will be monitored daily by the DON Or Administrator for compliance. Any corrections will be made immediately and discussed with the dietary staff daily. A report will be prepared monthly by the DON or Administrator and reviewed by the QA committee for Six months after substantial compliance is achieved. After six months of achieving substantial compliance Then the Dietary manager will complete a Monthly audit of compliance and present to QA for An additional 6 months. completion 09/05/2012	

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F 369	Continued From page 8 kitchen. At 5:50 PM the Dietary Manger (DM) acknowledged the tray card included the 3 compartment plate and styrofoam cups and stated it would not happen again. On 8/8/12 at 8:12 AM, Resident #13 had milk and ice cream in a large (12 ounce) styrofoam cup mixed together as a shake which she drank with a straw as it was positioned directly in front of her. On 8/8/12 at 8:17 AM an interview with MDS staff revealed Resident #13 was to get the styrofoam cups since 2010 since she was able to grasp these better. MDS further stated that Resident #13's granddaughter was her responsible party until April and did not permit occupational therapy to intervene as the granddaughter thought Resident #13 did not want attention brought to her for her feeding difficulties due to arthritis. On 8/8/12 at 9:29 AM the administrator stated the special eating devices should be listed on the tray card and should have been checked by staff at the time of tray delivery. The DM and Corporate DM were interviewed on 8/8/12 at 9:40 AM. They stated that the bottom of the tray card should be reserved for adaptive equipment and that because food items were also listed there, the adaptive equipment was missed. In addition they stated that the only styrofoam cups used by dietary are the 12 ounce size. The Corporate DM stated the styrofoam cups used by Resident #13 was provided so staff could make a shake from the ice cream and milk. They also stated the tray cards had been adjusted to ensure easier identification of assistive devices.	F 369		

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On 8/8/12, untimed, a clarification physician order was written for cups with handles discontinuing the styrofoam cups. The order continued with the use of a 3 compartment plate.

On 8/8/12 at 12:35 PM, a second tray was delivered to Resident #13 because the first plate was the regular plate not the 3 compartment plate. In addition, the resident was served a carton of milk, a hard plastic cup of tea, and a prefilled carton of juice and one cup with a handle. As the nurse aide who delivered the tray began to walk away, the MDS nurse took the handled cup off the tray. At this time the Corporate DM stated three cups with handles should have been served to Resident #13, one cup per liquid served.

Interview with Nurse Aide (NA) #4 on 8/8/12 at 2:11 PM revealed Resident #13 was very independent and tried to feed herself. NA #4 stated Resident #13 was able to pick up a handled cup and used a straw, however, she was unable to pick up a regular glass. NA #4 stated usually staff made milkshakes in the styrofoam cups from the milk and ice cream. She stated staff need to hold the cups without handles for Resident #13, however, she resisted assistance from staff.

Interview with NA #3 on 8/8/12 at 2:59 PM revealed she had known Resident #13 for many years, before coming to the facility. NA #3 described Resident #13 as very independent and wanted to feed herself. She stated her right hand only opened so much and she usually picked up a drink by the edge of the glass using her two

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F 369	Continued From page 10 fingers (thumb and first finger). She stated the resident's granddaughter came up with the idea of styrofoam which were used for milkshakes. NA #4 stated she needed a straw for her drinks as she bent forward to drink her liquids and not pick up the glass/cup. On 8/9/12 at 2:57 PM the Occupational Therapist (OT) was interviewed. She completed an evaluation this date and stated Resident #13 has no hand grasp and was only able to pinch with her thumb and first finger. If the food was not sticky, then Resident #13 had a lot of spillage, i.e. with peaches at the noon meal this date. OT further stated that when the resident's granddaughter was here she did not allow OT to intervene with Resident #13. OT stated Resident #13 could not grasp the handled cups without spillage due to left side hemiparesis, scoliosis and being bent forward. OT recommended trials for adaptive feeding equipment to aide Resident #13 in being able to feed herself with less spillage.	F 369		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	Plan of Correction F-428 Resident #17 medication list was reviewed during the survey for significant drug interactions and none were found. Subsequently the medication list was reviewed again by the pharmacies Clinical Manager and he found the same. After review by the attending physician it was decided to Discontinue the medication. Dc order 8/24/2012. Dr. Emerson discussed and reasons for discontinuation with the facilities QA committee On 8/29/12.	

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F 428	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the consultant pharmacist failed to report an irregularity related to medication administration findings for Cholestyramine (a cholesterol reducing medication) with potential drug-drug interactions, to the Director of Nursing or to the physician for one (1) of ten (10) residents reviewed for unnecessary medications. (Resident #17) The findings include: A review of the provider pharmacy auxiliary label and the product insert review of Cholestyramine included a boxed warning that Cholestyramine had to be given one hour prior to other medications or 4-6 hours after to reduce any drug-drug interactions related to absorption/distribution of other drugs. Resident #17 was admitted to the facility on 4/16/2009. The admitting diagnoses included high cholesterol, Diabetes Mellitus, Cerebrovascular accident and Glaucoma. A review of the physician orders dated 4/12/2012 included, Cholestyramine 4 G (gram) packet once daily with several other medications. A review of the Medication Administration Records (MAR) for the months of April 2012, May 2012, June 2012 July 2012 and August 2012 revealed that Cholestyramine 4 G packet was given and was scheduled at 9:00 AM with seven other medications. Review of the consultant pharmacists monthly	F 428	The physician orders for all residents were reviewed by the pharmacies Clinical Manager and no other residents were noted to be receiving cholestyramine or any other bile acid sequestrants. Going forward, the consultant pharmacist will review each medication regimen for appropriate medication administration based on the administration guidelines providing by the pharmacy or manufacture. Any recommendations regarding appropriate medication administration will be included in the monthly Medication Regimen Review report that is provided to the facility. Any trends, significant medication interactions or deviations from standards of practice will be reported to the Director of Nursing immediately. Nursing staff will be inserviced regarding the proper administration of medications based on the auxiliary labeling provided by the pharmacy. This inservice will be conducted to all licensed staff responsible for medication administration on 9/4/12 & 9/5/12 To ensure the accuracy of the Medication Regimen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345397	A. BUILDING _____ B. WING _____	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

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F 428	Continued From page 12 review notes documented on 4/6/2012, 5/4/2012, 6/8/2012 and 7/9/2012 and the pharmacy consultation reports did not reveal any recommendations related to the change in administration time of Cholestyramine one hour before other medications or 4 hours after the other medications to reduce drug interactions. A telephone interview with the consultant pharmacist on 8/6/12 at 2:20 PM revealed that each month he reviewed the physician order sheets, previous months MAR's and made recommendations related to changes in timings or strength of medications as needed. A follow up interview on the same day at 2:40 PM revealed that for Resident #17 the consultant pharmacist had not noticed that Cholestyramine was administered with other medications at the same time and stated there were no obvious drug-drug interactions with the current medications. The interview revealed that it would have been safer to administer Cholestyramine separately from other medications. An interview with Nurse (LN) #1 on 8/9/12 at 2:30 PM revealed that all physician order sheets and MAR's were printed at the pharmacy and the co-administration of Cholestyramine with other medication was not brought to her attention by the consultant pharmacist during the monthly reviews or by the provider pharmacy. LN #1 stated that she was not aware of the drug-drug interactions when Cholestyramine was given with other medications. An interview with the Director of Nursing on 8/9/2012 at 10:30 AM confirmed that for Resident #17 the consultant pharmacist had not brought	F 428	Review process a different consultant pharmacist will review the resident records until substantial compliance is achieved and for a period of 2 months thereafter. The pharmacies Clinical Manager will also review Medication Regimen Review processes with the existing consultant pharmacist and monitor this progress through the companies peer review evaluation process. Recommendations completed immediately and the DON will be notified. The results of this review will be reported to the facility QA team. Reports will be monitored Monthly at QA&A Date of correction 9/06/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	08/09/2012

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F 428	Continued From page 13 the discrepancy to her attention and she would change the Cholestyramine administration time to reduce potential drug-drug interactions.	F 428	* Submission of this plan And the actions put forth to carry out the completion of this Plan in no way constitute Admission of wrong Doing by the facility and its associates.	