

Department of Health & Human Services
Centers for Medicare & Medicaid Services 61
Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909



February 2, 2009

Administrator
Walter B. Jones A&D Abuse Treatment Center 2577
W. Fifth Street
Greenville, NC 27834

Re: Psychiatric Hospital CMS Certification Number (CCN): **34-4024**

Dear Administrator:

Enclosed is the Statement of Deficiencies (CMS-2567) prepared by representatives of the Centers for Medicare & Medicaid Services following their survey of your facility on **December 8-10, 2008**. Please enter your plan of correction in the space provided on the right-hand inside of this form. Each deficiency must be addressed. Your plan of correction should reference the appropriate prefix tag.

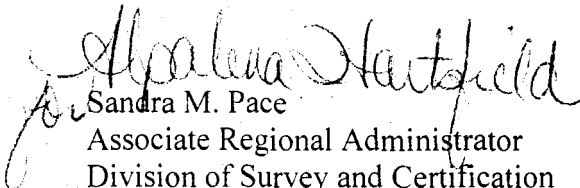
The plan of correction should state specifically how the deficiencies will be corrected, to include the time frame for completing the corrections. Statements such as "will be corrected", or "completed", will not be accepted. The completion date for each plan of correction should include the month, day, and year. If additional space is needed to complete the plan of correction, please attach a continuation page with the deficiencies clearly referenced. The facility's representative must sign and date the plan of correction.

You should retain a copy of the completed document for your records and return the original within 10 days to:

Sandra M. Pace, Associate Regional Administrator
Division of Survey and Certification
Centers for Medicare and Medicaid Services 61
Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909
Attn: Alpalena Hartsfield

If you have any questions or concerns about this matter, please contact Alpalena Hartsfield at (404) 562-7434.

Sincerely,


Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

Enclosure (CMS-2567)

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

Printed: 01/12/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X) PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 344024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2008
NAME OF PROVIDER OR SUPPLIER WALTER B. JONES A&D ABUSE TX. CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2577 W. FIFTH ST. GREENVILLE, NC 27834		
(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
B 000	INITIAL COMMENTS An unannounced recertification survey was conducted by federal consulting surveyors from December 8-10, 2008. The census at the beginning of this survey was 63 patients; the sample of active patients was 9.	B 000		
B 122	482.61(c)(1)(iii) TREATMENT PLAN The written plan must include the specific treatment modalities utilized. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to insure that the comprehensive treatment plans of 8 of 9 sample patients (A2, A3, B1, B2, B3, B4, B5 and C1) included nursing treatment modalities. This resulted in a treatment plan that did not reflect a comprehensive, integrated, individualized approach to multidisciplinary treatment and resulted in staff being unable to provide consistent approaches and focused treatment for patients' identified problems. Findings are: 1. Patient A2 was a 33 year-old male who was admitted on 12/3/08 with diagnoses of: 1) Polysubstance dependence (Opiates, Cocaine, Alcohol, Sedative Hypnotics Anxiolytics); 2) Cannabis abuse; 3) Nicotine dependence; 4) Opiate withdrawal; 5) Benzodiazepine withdrawal; 6) Alcohol withdrawal; and 7) Substance induced mood disorder. The Comprehensive Treatment Plan dated 12/3/08 did not identify any specific nursing modalities.	B 122		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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.

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

Printed: 01/12/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 344024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2008
NAME OF PROVIDER OR SUPPLIER WALTER B. JONES A&D ABUSE TX. CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2577 W. FIFTH ST. GREENVILLE, NC 27834		
(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
B 122	Continued From page 1 2. Patient A3 was a 36 year-old who was admitted on 12/3/08 with a long history of alcohol and cocaine use and recent vague suicidal ideations. He was diagnosed with: 1) Alcohol withdrawal; 2) Alcohol dependence; 3) Cocaine dependence; 4) Nicotine dependence; and 5) Substance induced mood disorder, depressed. The Comprehensive Treatment Plan dated 12/4/08 did not identify any specific nursing modalities. 3. Patient B1 was a 45 year-old male who was admitted on 12/1/08 for problems with use of cocaine, alcohol, opiates, marijuana and a recurrence of depression following the shooting death of his fiancé. He was diagnosed with: 1) Cocaine dependence; 2) Alcohol dependence; 3) Opiate dependence; 4) Marijuana dependence; and 5) Major Depressive Disorder, recurrent. He was also noted to have several chronic medical problems (hypertension, hypercholesterolemia, chronic back pain and hydradenitis). The Comprehensive Treatment Plan dated 12/1/08 did not identify any specific nursing modalities. 4. Patient B2 was admitted on 11/19/08 with a diagnosis of Alcohol and Opiate Dependence. He had a history of falling 3 stories with fractures of both legs and ankles, and suffered from chronic pain, for which he was prescribed Ultram and heat wraps to legs. He was on medication for hypertension and Trazadone for sleep. There were no nursing interventions noted on the treatment plan; this was confirmed by Nurse D during interview on 12/9/08 at 8:45 AM. 5. Patient B3 was admitted on 9/2/08 with a diagnosis of Cocaine, Alcohol and Opiate Dependence and Substance Induced Mood	B 122		

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

Printed: 01/12/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 344024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2008
NAME OF PROVIDER OR SUPPLIER WALTER B. JONES A&D ABUSE TX. CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2577 W. FIFTH ST. GREENVILLE, NC 27834		
(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
B 122	<p>Continued From page 2</p> <p>Disorder and was 6 months pregnant. She was on Methadone and Haldol, suffered from migraines and chronic ankle pain, and had an abdominal wound subsequent to a liver and spleen repair following a stabbing. She also had a history of pre-eclampsia. There were no nursing interventions noted on the treatment plan; this was confirmed by Nurse C during interview on 12/9/08 at 9:00 AM.</p> <p>6. Patient B4 was admitted on 10/24/08 with a diagnosis of Cocaine Dependence. She gave birth on 12/8/08 and returned to the ASR Unit on 12/9/08 with her 1 day old infant. She was on Zyrtec, Motrin and Colace and was meeting with an RN to procure formula and diapers. There were no nursing interventions noted on the treatment plan and this was confirmed by RN A during interview on 12/9/08 at 9:30 AM.</p> <p>7. Patient B5 was admitted on 12/1/08 with a diagnosis of Opiate Dependence and Major Depression. She was on Methadone, Celexa, Provigil, Lisinopril and Prilosec. She suffered from hypertension, GERD and chronic back pain. She was depressed and homeless and had just been told that her mother did not want her to return to her home. There were no nursing interventions on the treatment plan; this was confirmed by RN A during interview on 12/09/08 at 10:00 AM.</p> <p>8. Patient C1 was admitted 11/17/08 with a diagnosis of Cocaine Dependence. She was part of the Perinatal Program and her twin 5 month old infants resided on the Unit with her. She was subsequently found to have depression and started on Prozac. She suffered headaches and a fluctuating blood pressure. The surveyor was told by Nurse A during interview on the Unit on</p>	B 122		

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

Printed: 01/12/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 344024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2008
NAME OF PROVIDER OR SUPPLIER WALTER B. JONES A&D ABUSE TX. CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2577 W. FIFTH ST. GREENVILLE, NC 27834		
(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
B 122	Continued From page 3 12/9/08 at 8:30 AM that nursing may assist with care of the infants on the night shift with a Doctor's order. She also confirmed at that time that there were no nursing interventions on the treatment plan. 9. The records of Patients B2, B3, B4, B5 and C1 were reviewed by the Director of Nursing and Nurse Supervisor during a meeting with them on 12/9/08 at 11:00 AM. They confirmed that there were no nursing interventions on these treatment plans.	B 122		
B 147	482.62(d)(1) NURSING SERVICES The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. This Standard is not met as evidenced by: Based on interview and data review it was determined that the facility failed to have a Director of Nursing with a Master's Degree, psychiatric nursing experience, or consultation from a nurse with a Master's Degree in Psychiatric/Mental Health Nursing. Findings are: 1. Review of the resume of the Director of Nursing revealed that her highest level of education was an Associate Degree in Nursing. 2. The Director of Nursing, in a meeting at 11:00	B 147		

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

Printed: 01/12/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 344024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2008
NAME OF PROVIDER OR SUPPLIER WALTER B. JONES A&D ABUSE TX. CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2577 W. FIFTH ST. GREENVILLE, NC 27834		
(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
B 147	Continued From page 4 AM on 12/9/08, stated that she does not have access to a Master's prepared nurse for consultation.	B 147		
B 148	482.62(d)(1) NURSING SERVICES The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished. This Standard is not met as evidenced by: Based on interview and record review it was determined that the Director of Nursing failed to ensure that the treatment plans of 8 of 9 sample patients (A2, A3, B1, B2, B3, B4, B5 and C1) delineated the RN role in the care of the patients. This resulted in a treatment plan that did not reflect a comprehensive, integrated, individualized approach to multidisciplinary treatment and resulted in staff being unable to provide consistent approaches and focused treatment for patients' identified problems. (Refer to B122.)	B 148		