

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 000	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on October 29, 2025. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment.</p> <p>This facility has a current census of 276. The survey sample consisted of audits of 13 current clients and 1 deceased client.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. 	V 112	<p>RECEIVED</p> <p>NOV 10 2025</p> <p>DHSR-MH Licensure Sect</p>	

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

TITLE

President and CEO

(X6) DATE

11.05.2025

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CROSSROADS TREATMENT CENTER OF ASHEVILLE **6 ROBERTS ROAD, SUITE 103**
ASHEVILLE, NC 28803

(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop treatment plans based on client needs for 4 out of 14 audited clients (#6, #8, #12 and #13), failed to review and update the treatment plan annually for 3 out of 14 audited clients (#3, #11, and Deceased Client #14 (DC #14)), and failed to obtain written consent by a responsible party for a client's treatment plan affecting 2 out of 14 audited clients, (#2 and #9). The findings are:</p> <p>Finding #1:</p> <p>Review on 10/28/25 of Client #6's record revealed: -Date of Admission: 7/7/25. -Diagnosis: Opioid Use Disorder, severe. -No documentation of a treatment plan.</p> <p>Review on 10/28/25 of Client #8's record revealed: -Date of Admission: 5/6/22. -Diagnosis: Opioid Use Disorder, severe. -No documentation of a treatment plan.</p> <p>Review on 10/28/25 of Client #12's record revealed: -Date of Admission: 11/27/23. -Diagnosis: Opioid Use Disorder, moderate. -Treatment plan dated 10/20/25: no goals or strategies for substance use disorder.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 112	<p>Continued From page 2</p> <p>Review on 10/28/25 of Client #13's record revealed: -Date of Admission: 3/27/25. -Diagnosis: Opioid Use Disorder, severe. -No documentation of a treatment plan.</p> <p>Finding #2:</p> <p>Review on 10/28/25 of Client #3's record revealed: -Date of Admission: 8/19/24. -Diagnosis: Opioid Use Disorder, severe. -Treatment plan dated 8/19/24 expired.</p> <p>Review on 10/28/25 of Client #11's record revealed: -Date of Admission: 7/27/18. -Diagnosis: Opioid Use Disorder, severe. -Treatment plan dated 2/15/24 expired.</p> <p>Review on 10/28/25 of DC #14's record revealed: -Date of Admission: 8/23/18. -Diagnoses: Opioid Use Disorder, severe and Chronic Obstructive Pulmonary Disease. -Treatment plan dated 5/14/24 expired.</p> <p>Interview on 10/27/25 with Client #3 revealed: -Had goals to "stay clean...get a place to live...homeless right now...have legal problems." -Went over his goals with the Clinical Director "2 to 3 weeks ago."</p> <p>Finding #3:</p> <p>Review on 10/28/25 of Client #2's record revealed: -Date of Admission: 5/12/24. -Diagnosis: Opioid Use Disorder. -No written consent by a responsible party for the</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 112	<p>Continued From page 3 treatment plan dated 5/20/25.</p> <p>Review on 10/28/25 of Client #9's record revealed: -Date of Admission: 9/26/18. -Diagnosis: Opioid Use Disorder, severe. -No written consent by a responsible party for the treatment plan dated 6/12/25.</p> <p>Interview on 10/29/25 with Counselor 2 revealed: -Responsible to complete the treatment plans for her caseload. -"A lot of them (treatment plans) trying to get caught up...a lot of them are behind and a lot of them disappeared when we changed providers (physician) and computer systems...a lot didn't get scanned (into new computer system)...I have seen a lot of signature pages that did not get scanned in..."</p> <p>Interview on 10/28/25 with the Clinical Director revealed: -Some client treatment plans were late or missing. -There was a lot of staff turnover and the computer system was changed. -"...A lot (of treatment plans) have been lost in the shuffle...we are still trying to get caught up...they (clients) have been flagged in the (computer) system for (treatment plan) updates..."</p> <p>Interview on 10/28/25 with the Senior Manager of Clinical Compliance revealed: -"Want to be transparent." -There was a change in the electronic records system last May 2024 "and then Hurricane Helene (9/2024) and staffing has changed multiple times." -"We know (client) files aren't where they need to be..."</p>	V 112	<p>In response to tag V112, the Director of Clinical Compliance conducted Back to Basics trainings with the Crossroads Treatment Center of Asheville, P.C. clinical teammates from August 4, 2025 through October 31, 2025 to cover the following topics: state regulatory standards, Crossroads policies and procedures, CARF Organization Standards, and CARF Program Standards. More specifically, training regarding the requirements for assessment and treatment planning was completed on October 1, 2025.</p> <p>Starting immediately, the Clinical Director will develop an internal tracking spreadsheet that outlines the due dates for all patients, including LME/MCO recipients, that are enrolled in clinical services at Crossroads Treatment Centers of Asheville, P.C.. This tracking spreadsheet will be updated weekly by the clinical counselors and submitted to the Clinical Director for review. Monthly, the Program Director will conduct an audit of the internal tracking spreadsheet, and provide feedback to the Director of Clinical Compliance in the scheduled touch base calls. To assist with auditing the completion of treatment plans, The Compliance Auditor Coordinators, under the direction of the Director of Clinical Compliance, will continue to audit for treatment plan frequency in monthly clinical compliance audits.</p> <p>By November 7, 2025, the Director of Clinical Compliance will schedule bimonthly touchbases with the Program Director, Clinical director, and Regional Director for Crossroads Treatment Centers of Asheville, P.C. to review compliance factors and tracking of the completion of this Plan of Correction. These bimonthly touchbases will end on December 31, 2025. Following the completion of the bimonthly touchbases, it will be responsibility of the Clinical Director, with Program Director oversight, to ensure that all treatment plans are completed prior to the expiration date moving forward.</p> <p>By November 14, 2025, the Crossroads Treatment Center of Asheville, P.C. Clinical Director, with the support of the Program Director and Director of Clinical Compliance, will conduct a clinical training session reviewing the requirements for assessment of patient goals, documentation of the patient's goals on the treatment plan, what signatures are needed on the treatment plan, and how to link any person centered plans to the patient's electronic health record. The Clinical Director will submit an internal Training Log for the training provided to the Director of Clinical Compliance for tracking of this completion date.</p> <p>By November 30, 2025, all patients enrolled at Crossroads Treatment Center of Asheville, P.C. will have an active treatment plan on file, that is readily available in their electronic health record, that has the appropriate signatures (Patient, Counselor, Supervising Counselor, and Program Practitioner, as applicable).</p>	November 30, 2025

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 113	<p>27G .0206 Client Records</p> <p>10A NCAC 27G .0206 CLIENT RECORDS</p> <p>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:</p> <p>(1) an identification face sheet which includes:</p> <p>(A) name (last, first, middle, maiden);</p> <p>(B) client record number;</p> <p>(C) date of birth;</p> <p>(D) race, gender and marital status;</p> <p>(E) admission date;</p> <p>(F) discharge date;</p> <p>(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;</p> <p>(3) documentation of the screening and assessment;</p> <p>(4) treatment/habilitation or service plan;</p> <p>(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;</p> <p>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;</p> <p>(7) documentation of services provided;</p> <p>(8) documentation of progress toward outcomes;</p> <p>(9) if applicable:</p> <p>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);</p> <p>(B) medication orders;</p> <p>(C) orders and copies of lab tests; and</p> <p>(D) documentation of medication and administration errors and adverse drug reactions.</p> <p>(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed</p>	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 113	<p>Continued From page 5</p> <p>only in accordance with the communicable disease laws as specified in G.S. 130A-143.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete client records affecting 14 out of 14 audited clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and Deceased Client #14 (DC #14)). The findings are:</p> <p>Review on 10/28/25 of Client #1's record revealed: -Date of Admission: 2/10/25. -Diagnoses: Opioid Use Disorder (D/O), Severe. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #2's record revealed: -Date of Admission: 5/12/24. -Diagnoses: Opioid Use D/O. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #3's record revealed: -Date of Admission: 8/19/24. -Diagnoses: Opioid Use Disorder D/O, Severe. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p>	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 113	<p>Continued From page 6</p> <p>Review on 10/28/25 of Client #4's record revealed: -Date of Admission: 4/26/13. -Diagnoses: Opioid Use D/O, Severe. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #5's record revealed: -Date of Admission: 11/23/18. -Diagnoses: Opioid Use D/O; Hypertension; and Hyperlipidemia. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #6's record revealed: -Date of Admission: 7/7/25. -Diagnoses: Opioid Use Disorder D/O, Severe. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #7's record revealed: -Date of Admission: 2/5/25. -Diagnoses: Opioid Use D/O; Amphetamine Use D/O; Stimulant Use D/O Severe; and Other or Unspecified Stimulant Use D/O. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #8's record revealed: -Date of Admission: 5/6/22. -Diagnoses: Opioid Use Disorder D/O, Severe.</p>	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 113	<p>Continued From page 7</p> <p>-No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #9's record revealed: -Date of Admission: 9/26/18. -Diagnoses: Opioid Use Disorder D/O, Severe. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #10's record revealed: -Date of Admission: 7/27/17. -Diagnoses: Opioid Use Disorder D/O, Severe. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #11's record revealed: -Date of Admission: 7/27/18. -Diagnoses: Opioid Use Disorder D/O, Severe. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #12's record revealed: -Date of Admission: 11/27/23. -Diagnoses: Opioid Use Disorder D/O, Moderate. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of Client #13's record revealed: -Date of Admission: 3/27/25. -Diagnoses: Opioid Use Disorder D/O, Severe.</p>	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 113	<p>Continued From page 8</p> <p>-No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Review on 10/28/25 of DC #14's record revealed: -Date of Admission: 8/23/18. -Diagnoses: Opioid Use Disorder D/O, Severe and Chronic Obstructive Pulmonary Disease. -No written consent by the legally responsible person granting permission to seek emergency care if needed.</p> <p>Interview on 10/28/25 with the Senior Clinical Compliance Manager revealed: -The written consent for emergency treatment was taken out of client files in the summer of 2024. -The legal team for the Licensee advised that there didn't need to be written consent to contact emergency services for clients. -Based on compliance with Division of Health Service Regulation (DHSR) licensure rules for the program, the consent for emergency care will be added back in to the client files.</p>	V 113	<p>In response to V113, the Director of Clinical Compliance has communicated the need to update the Consent to Contact housed in the Clinical Consent bundle to the Crossroads Clinical Applications Team. The Director of Clinical Compliance has completed the appropriate documentation for the change, and will staff the change in the internal Crossroads Steering Committee by November 20, 2025. Upon the approval from the internal Clinical Applications Steering Committee, the Director of Clinical Compliance will be responsible for testing the new form, providing communication to the center leaders, and any trainings. The Consent to Contact will be updated in the patient's charts by November 30, 2025 with all patients enrolled in services at Crossroads Treatment Centers of Asheville, P.C. signing the new consent by December 28, 2025.</p> <p>Moving forward, it will be the responsibility of the Clinical Director to ensure that the Consent to Contact is signed for all patients enrolled in services at Crossroads Treatment Center of Asheville, P.C. at intake and annually. To assist in tracking consent bundle completions, the Compliance Audit Coordinators, under the direction of the Director of Clinical Compliance, will continue to audit each patient's clinical consent bundle that is selected within the identified sample size monthly.</p>	December 28, 2025
V 537	<p>27E .0108 Client Rights - Training in Sec Rest & ITO</p> <p>10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 537	<p>Continued From page 9</p> <p>(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.</p> <p>(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.</p> <p>(g) Acceptable training programs shall include, but are not limited to, presentation of:</p> <ol style="list-style-type: none"> (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; 	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CROSSROADS TREATMENT CENTER OF ASHEVILLE **6 ROBERTS ROAD, SUITE 103**
ASHEVILLE, NC 28803

(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 537	<p>Continued From page 10</p> <p>(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;</p> <p>(6) prohibited procedures;</p> <p>(7) debriefing strategies, including their importance and purpose; and</p> <p>(8) documentation methods/procedures.</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualification and Training Requirements:</p> <p>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.</p> <p>(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 537	<p>Continued From page 11</p> <p>(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.</p> <p>(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) evaluation of trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.</p> <p>(8) Trainers shall be currently trained in CPR.</p> <p>(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.</p> <p>(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.</p> <p>(11) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcome (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(l) Qualifications of Coaches:</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**CROSSROADS TREATMENT CENTER OF ASHEVILLE 6 ROBERTS ROAD, SUITE 103
ASHEVILLE, NC 28803**

(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 537	<p>Continued From page 13</p> <p>Review on 10/27/25 of Counselor #2's personnel record revealed: -Date of Hire: 12/30/24. -Position: Counselor. CADC-1. -NCI Training on Physical Interventions dated 1/22/25, were from an electronic, online training platform (Relias) with no expiration date documented. -Crisis Prevention and Protective Intervention Program Observation (of staff) through Relias was completed by the Program Director, dated 1/24/25. -No evidence of in person training for RI or observation of staff competency by a certified instructor.</p> <p>Review on 10/27/25 of LPN #1's personnel record revealed: -Date of hire: 6/27/22. -Position: Dosing nurse. -NCI: Training on Physical Interventions dated 3/8/25, were from an electronic, online training platform with no expiration date documented. -No evidence of in person training for RI or observation of staff competency by a certified instructor.</p> <p>Interview on 10/28/25 with Counselor #1 revealed: -Worked at the facility since August of 2024. -Completed RI training through the electronic, online learning platform (Relias) the facility used. - "Only training in person I've had was supervision from [Clinical Director]."</p> <p>Interview on 10/27/25 with the Clinical Director revealed: -Facility staff had not completed RI training in person "since COVID," because of schedules.</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/29/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CROSSROADS TREATMENT CENTER OF ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6 ROBERTS ROAD, SUITE 103 ASHEVILLE, NC 28803
---	---

(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 537	<p>Continued From page 14</p> <p>-The facility used an online training platform for RI training, and the Program Director (PD) observed staff.</p> <p>Interview on 10/28/25 with the Senior Clinical Compliance Manager revealed: -The facility had a staff member in the past that trained on RI. -Had a hard time getting someone scheduled to do the in-person portion of the training.</p> <p>Interviews from 10/27/25 to 10/29/25 with the PD revealed: -Not certified as an instructor for Non-Violent Crisis Intervention (NCI), the restrictive intervention curriculum used by the facility.</p>	V 537	<p>In response to tag V537, the Program Director will identify a Non-Violent Crisis Intervention (NCI) trainer to present to the center by December 28, 2025 to conduct an all staff training. The completion of the training will be documented in the each Crossroads Treatment Center of Asheville, P.C. teammate's personnel file, that is managed electronically by the Crossroads People and Culture Department.</p> <p>By November 30, 2025, the Senior Manager of Personnel Compliance will update all applicable Required Training tables to outline the requirement to have the skill's portion of the training completed by an Instructor of Non-Violent Crisis Intervention.</p> <p>Moving forward, it will be the responsibility to ensure that all center teammates receive Non-Violent Crisis Intervention training by a certified individual in accordance with 10A NCAC 27E .0108 Client Rights.</p>	December 28, 2025