

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>UPWARD PROCESS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>568 ALLEGHANY ROAD</b> <b>FAYETTEVILLE, NC 28304</b>		
(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	INITIAL COMMENTS  An annual and follow up survey was completed on June 10, 2025. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.  This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements  10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.	V 108		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>UPWARD PROCESS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>568 ALLEGHANY ROAD</b> <b>FAYETTEVILLE, NC 28304</b>		
(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 108	Continued From page 1  (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.  This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 audited staff (Director) were currently trained in Cardiopulmonary Resuscitation (CPR) and First Aid. The findings are:  Review on 06/10/25 of the Director's personnel record revealed: -Hire Date: 09/05/12. -Job Title: Director -The CPR/First Aid expired on 05/15/25.  During interview on 06/10/25 the Director revealed: -He worked most of the shifts and it was only 1 staff working on each shift. -He was a trainer for CPR/First Aid. -He would ensure his training was completed.	V 108		
V 114	27G .0207 Emergency Plans and Supplies  10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>UPWARD PROCESS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>568 ALLEGHANY ROAD</b> <b>FAYETTEVILLE, NC 28304</b>		
(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 114	<p>Continued From page 2</p> <p>request. The plans shall include evacuation procedures and routes.</p> <p>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies.</p> <p>(d) Each facility shall have a first aid kit accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were held at least quarterly and repeated on each shift. The findings are:</p> <p>Review on 06/10/25 of the documentation provided by the Director revealed on one fire and disaster drill had been documented on 09/16-25 at 4:00pm 2nd shift for a fire drill and 06/16/24 at 8:15am 1st shift for a disaster drill.</p> <p>During interview on 06/10/25 client #1, #2 and #3 revealed they all completed fire and disaster drills and described the locations and actions to complete for each drill.</p> <p>During interview on 06/10/25 the Director revealed: -Fire and Disaster drills had been completed but</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>UPWARD PROCESS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>568 ALLEGHANY ROAD</b> <b>FAYETTEVILLE, NC 28304</b>		
(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 114	Continued From page 3  he did not know where the documentation for the drills were at the time of the survey.	V 114		
V 118	27G .0209 (C) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>UPWARD PROCESS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>568 ALLEGHANY ROAD</b> <b>FAYETTEVILLE, NC 28304</b>		
(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 118	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to keep the MARs current for 2 of 3 clients (#2 and #3). The findings are:</p> <p>Review on 06/10/25 client #2's record revealed: - Admission date of 11/30/12. - Diagnoses of Schizophrenia Paranoid Type Disorder and Borderline Intellectual Developmental Disability.</p> <p>Review on 06/10/25 of client #2's physician orders dated 05/30/25 revealed: -Cyproheptad 4mg Take 1 tablet by mouth twice a day. -Docusate Sodium 100 mg (constipation) Take 1 capsule by mouth twice a day. -Lorazepam 0.5mg (agitation) Take 1 tablet by mouth twice a day. -Oxybutynin 5mg (over active bladder) Take 1 tablet by mouth twice a day. -Ibuprofen 400mg (pain) Take 1 tablet by mouth three times a day. -Zenpep 10,000 (exocrine pancreatic insufficiency) Take 3 capsules by mouth with meals four times a day. -Aripiprazole 30mg (antipsychotic) Take 1 tablet by mouth every evening. -Trazodone 300mg (insomnia) Take 1 tablet by mouth at bedtime.</p> <p>Review on 06/10/25 of client #2's June 2025 MAR revealed the following dates with no initials to indicate the medication had been administered: -Cyproheptad 4mg-06/2/25-06/07/25 at 8pm. -Docusate Sodium 100mg-06/02/25-06/07/25 at 8pm.</p>	V 118			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>UPWARD PROCESS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>568 ALLEGHANY ROAD</b> <b>FAYETTEVILLE, NC 28304</b>		
(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 118	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-Lorazepam 0.5mg-06/02/25-06/07/25 at 8pm.</li> <li>-Oxybutynin 5mg-06/02/25-06/07/25 at 8pm.</li> <li>-Ibuprofen 400mg-06/02/25-06/07/25 at 8pm.</li> <li>-Zenpep 10, 000-06/02/25-06/07/25 at 8pm.</li> <li>-Aripiprazole 30mg-06/02/25-06/07/25 at 8pm.</li> <li>-Trazodone 300mg- 06/02/25-06/07/25 at 8pm.</li> </ul> <p>During interview on 06/10/25 client #2 revealed: -He took his medication every day and would take his medication in the morning and at night.</p> <p>Review on 06/10/25 of client #3's record revealed: -Admission date of 01/28/13. -Diagnoses of Major Depressive Disorder and Generalized Anxiety Disorder.</p> <p>Review on 06/10/25 of client #3's physician orders dated 05/30/25 revealed: -Citalopram 40mg (depression) Take 1 tablet by mouth every day. -Fluticasone Nasal Spray 50mcg (allergies) 2 sprays into each nostril every day. -Levetiracetam 500mg (seizures) Take 4 tablets by mouth every day. -Losartan/HCTZ 50-12.5 (blood pressure) Take 1 tablet by mouth every day. -Vitamin B12 100mcg (deficiency) Take 1 tablet under the tongue every morning. -Buspirone 15mg (anxiety) Take 1 tablet by mouth twice a day. -Celecoxib 100mg (anti-inflammatory) Take 1 capsule by mouth twice a day for low back pain. -Famotidine 20mg (heartburn) Take 1 tablet by mouth twice a day. -Risperidone 2mg (antipsychotic) Take 1 tablet by mouth twice a day. -Latanoprost 0.05% (dry eye) Instill 1 drop in each eye every evening. -Loratadine 10mg (allergies) Take 1 tablet by</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>UPWARD PROCESS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>568 ALLEGHANY ROAD</b> <b>FAYETTEVILLE, NC 28304</b>		
(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 118	<p>Continued From page 6</p> <p>mouth at bedtime. -Mirtazapine 30mg (depression) Take 1 tablet by mouth at bedtime. -Phenytoin 100mg (seizures) Take 3 capsules by mouth every night at bedtime.</p> <p>Review on 06/10/25 of client #3's June 2025 MAR revealed the dates with no initials to indicate the medication had been administered: -Citalopram 40mg-06/10/25 at 8am. -Fluticasone Nasal Spray 50mcg-06/10/25 at 8am. -Levetiracetam 500mg-06/10/25 at 8am. -Losartan/HCTZ 50-12.5-06/10/25 at 8am. -Vitamin B-12 100mcg-06/10/25 at 8am. -Buspirone 15mg- 06/2/2025-06/07/25, 06/09/25 at 8pm. -Celecoxib 100mg-06/10/25 at 8am, 06/02/25-06/07/25, 06/09/25 at 8pm. -Famotidine 20mg-06/10/25 at 8am, 06/02/25-06/07/25, 06/09/25 at 8pm. -Risperidone 2mg-06/10/25 at 8am, 06/02/05-06/07/25, 06/09/25 at 8pm. -Latanoprost 0.005%-06/01/25-06/09/25. -Loratadine 10mg-06/02/25-06/07/25, 06/09/25 at 8pm. -Mirtazapine 30mg-06/02/25-06/07/25, 06/09/25 at 8pm. -Phenytoin 100mg-06/02/25-06/07/25, 06/09/25 at 8pm. -Simvastatin 20mg-06/02/25-06/07/25, 06/09/25 at 8pm.</p> <p>During interview on 06/10/25 client #3 revealed: -He always took his medication and had never missed taking his medication.</p> <p>During interview on 06/10/25 the Director revealed: -He had a difficult year and knew he had made</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/10/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>UPWARD PROCESS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>568 ALLEGHANY ROAD</b> <b>FAYETTEVILLE, NC 28304</b>		
(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 118	Continued From page 7  some mistakes. -The clients always got the medication and staff did not document correctly.	V 118			