STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL063009	A. BUILDING: _____ B. WING _____	09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH FAMILY CARE	128 NORTH CARLISLE STREET SOUTHERN PINES, NC 28387

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/17/26.	C 000		
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure there was a continuously sounding device that was activated when the door was opened for 1 of 3 sampled residents (#3) determined by a physician to be intermittently disoriented The findings are: Observations upon entrance to the facility on 09/17/26 at 8:00am and intermittently throughout	C 069		

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C 069	Continued From page 1 the day until 3:00pm revealed: -There was a beep sound when the front exterior and interior entrance/ exit doors were opened. -The sounding device did not sound continuously. -There was a resident sitting outside the front entrance. -There were 2 entrance/ exit doors easily accessible to the residents. Review of Resident #3's current FL-2 dated 09/15/26 revealed: -Diagnoses included dementia, hypertension, seizure disorder, and vitamin D deficiency. -Her disorientation was intermittent. Interview with the Administrator on 09/17/26 at 2:05pm revealed: -There was an alarm on the doors so they would know when a resident went out. -She did not know there should be a continuous sounding device on the doors for residents who were intermittently disoriented. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	C 069		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.	C 202		

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C 202	Continued From page 2	C 202		

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to ensure 1 of 3 sampled residents (#3) was tested for tuberculosis (TB) disease in compliance with the control measures adopted by the Commission for Public Health.

The findings are:

Review of Resident #3's current FL-2 dated 09/15/26 revealed:
-Diagnoses included dementia, hypertension, seizure disorder, and vitamin D deficiency.
-Her disorientation was intermittent.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 08/25/26.

Review of Resident #3's record on 09/17/26 revealed:
-There was a chest x-ray completed on 08/18/26.
-The chest x-ray was indicated to determine the results for pneumonia.
-There was no documentation of a 2-step TB skin test or chest x-ray indicating tuberculosis was administered and read.

Interview with the Administrator on 09/17/26 at 2:15pm revealed:
-She requested Resident #3's chest x-ray for TB.
-She read the chest x-ray results that indicated Resident #3 was clear for pneumonia.
-She thought Resident #3's chest x-ray was the

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C 202	Continued From page 3 right one for TB. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	C 202		
C 261	10A NCAC 13G .0904 (b)(1) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service (b) Food Preparation and Service in Family Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure table service consisted of non-disposable place settings consisting of a knife, fork, spoon and plate. The findings are: Observation during the breakfast meal on 09/17/26 between 8:11am and 8:30am revealed: -The meal was served on disposable plates with a plastic fork. -There was no knife or spoon at the place settings. Interview with the Administrator on 09/17/26 at 2:16pm revealed: -She used disposable plates this morning because she scheduled to take the residents on outing and was in a rush. -She knew disposable plates and forks were not	C 261		

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C 261	Continued From page 4 to be used during meals.	C 261		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	C 335		

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C 335	Continued From page 5 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to protect medications from contamination that were prepared for administration in advance for 3 of 3 sampled residents (#1, #2, and 3). The findings are: Observation between 8:00 and 8:11am revealed: -There were 3 place settings on the table with medications at each place setting. -There was a multi dose pack of medication on the table with a resident's name on the pack. -There were 2 medication cups on the table that contained pills. -The medication cups on the table were not covered. 1. Review of Resident #1's current FL-2 dated 05/12/26 revealed diagnoses included modern intellectual disability, seizure disorder, schizophrenia, anxiety, and hypertension. Observation of Resident #1's medications on 09/17/26 between 8:00am and 8:11am revealed: -There were 7 pills in a medication cup on the dining room table. -The medication cup was not sealed and identified. Interview with the Administrator on 09/17/26 at 2:05pm revealed Resident #1's medication came in a multi-dose pack but she opened it because it was hard for him to open the pack. Refer to interview with the Administrator on 09/17/26 at 2:05pm.	C 335		

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C 335	Continued From page 6 2. Review of Resident #2's current FL-2 dated 07/21/26 revealed diagnoses included bipolar disorder, autism spectrum disorder, hypertension, and hyperlipidemia. Observation of Resident #2's medications on 09/17/26 between 8:00am and 8:11am revealed: -There was a multi-dose pack of medication on the table with the resident's name displayed. -The multi-dose pack was not kept in a capped or sealed container. Refer to interview with the Administrator on 09/17/26 at 2:05pm. 3. Review of Resident #3's current FL-2 dated 09/15/26 revealed diagnoses included dementia, hypertension, seizure disorder, and vitamin D deficiency. Observation of Resident #3's medications on 09/17/26 between 8:00am and 8:11am revealed: -There were 4 pills in a medication cup. -The medication cup was not sealed and identified. Refer to interview with the Administrator on 09/17/26 at 2:05pm. _____ Interview with the Administrator on 09/17/26 at 2:05pm revealed: -She usually waited until the residents came into the dining room before she gave them their medications, but she was rushing this morning to take them on an outing. -She knew the medications should have been covered but she was rushing.	C 335		