STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BURKE ASSISTED LIVING	125 CAMELLIA GARDEN STREET MORGANTON, NC 28655

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/31/26-04/01/26.	D 000		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon. The findings are: Observation of the dining room and living room area where the lunch meal was served on 03/31/26 at 12:00pm revealed: -The tables were set for lunch. -Table service included a spoon and fork but did not include a knife. -Some of the residents were observed cutting up cooked sliced apples with a spoon or fork.	D 286		

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D 286	Continued From page 1 Interview with one resident on 04/01/26 at 8:50am revealed: -He was never provided with a knife with his meals. -He had to use the side of a fork to cut up his food. -He would like a knife to cut up his food because sometimes it was hard to cut meat. -Staff told him he was not allowed to have a knife, and they could cut up his food for him. -He did not like being dependent on staff to cut up his food for him. Interview with a second resident on 04/01/26 at 8:53am revealed: -He never got a knife to use with his meals. -He had to ask staff to cut food up for him when he could not cut it up with a fork or spoon. -He wanted a knife provided with his meals. -He was never told by staff why he could not have a knife to use with his meals, but it made him feel like a child when he had to rely on staff to help him. Interview with a third resident on 04/01/26 at 8:56am revealed: -She was never given a knife to use with her meals. -Staff had to cut up her food because she could not cut it with a spoon or fork sometimes. -She asked staff for a knife and was told she could not have a knife, but the staff member did not say why. Interview with a fourth resident on 04/01/26 at 9:02am revealed: -She never got a knife with meals and was only given a spoon or fork. -The staff would cut up the food for her if she needed it when she could not cut the food with a	D 286		

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spoon or fork.
-She was never told why she was not allowed to have a knife with her meals.
-She would like a knife to use during meals.

Interview with a fifth resident on 04/01/26 at 9:06am revealed:
-She was never provided with a knife to use during meals.
-She had to ask staff to cut her food if it was not already cut up.
-She would like to be provided with a knife for use during meals.

Interview with the cook on 03/31/26 at 10:00am revealed:
-She was responsible for the place settings for meals.
-She only gave the residents a fork and spoon to use during the meal service.
-She did not give any of the residents a knife to use during meals because one of the residents threatened to harm her in the past.
-Staff could cut up food for residents if the residents needed anything cut up.
-She had several residents with a chopped diet, so she chopped up the meat in the kitchen for them.

Interview with the Administrator on 04/01/26 at 8:40am revealed:
-She was not aware knives were not being provided to the residents for use during the meal service.
-She expected staff to cut up the food for the residents if knives were not provided during meals.
-Residents should get a full place setting consisting of a knife, fork, and spoon to be used during meals.

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D 291	10A NCAC 13F .0904(c)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have therapeutic menus in the kitchen for the guidance of food service staff. The findings are: Observation of the kitchen on 03/31/26 at 9:59am revealed: -There were eight resident names handwritten on a white board who had orders for a chopped diet. -There was no therapeutic diet menu posted in the kitchen. Interview with a cook on 03/31/26 at 10:00am revealed: -She did not have a therapeutic diet menu available. -She was never provided with a therapeutic diet menu to use for guidance. -The facility did not offer therapeutic diets and just chopped the food into pieces if the residents	D 291		

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needed it.
-The Administrator usually sent regular menus weekly, but she had not received a regular menu since the previous menu dated 02/18/26-02/24/26 was sent.
-She asked the Manager for a menu and the Manager told her she asked the Administrator for it and it was never sent.

Review of the resident diet orders on 03/31/26 revealed there were 3 of 3 sampled residents (#1, #2, and #3) who had orders for a chopped diet.

Interview with the facility's contracted dietician on 04/01/26 at 11:44am revealed:
-She worked for the company that supplied menus to the facility.
-A chopped diet was a modified texture diet and was considered a therapeutic diet.
-The facility should use the therapeutic diet menu for chopped diet for guidance of food service staff because chopped had very specific modifications and the pieces of food should not be any larger than ½ inch.
-The therapeutic diet menus were available on the company website for printing.
-The facility did not currently have access to print the menus because the most recent subscription was cancelled due to non-payment from 12/20/26-04/01/26.

Interview with the Manager on 03/31/26 at 12:40pm revealed:
-The facility did not have therapeutic diet menus.
-She was not aware a chopped diet was considered a therapeutic diet.
-The cook just chopped up whatever was being served for the day for residents with orders for a chopped diet.

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D 291	Continued From page 5 Interview with the Administrator on 04/01/26 at 8:40am revealed: -The facility's contracted food supply company provided therapeutic diet menus that she or the Maintenance Director could print off the computer. -The facility did not have any residents with therapeutic diets ordered. -Some residents had orders for a chopped diet. -The cook followed the regular menu and chopped the food up for the residents with orders for chopped diet. Telephone interview with the Maintenance Director on 04/01/26 at 1:22pm revealed: -The Administrator emailed him menus, and he printed them and gave them to the facility every Friday. -He had not taken a menu to the facility since February 2026 because he was working at sister facilities. -He did not think there was a menu for a chopped diet. -All residents who had orders for a chopped diet got the regular menus food items chopped up. -He created a menu from an old menu on 03/31/26 and sent it to the facility for the cook to post in the kitchen. -He was able to edit old menus in the computer system from the facility's contracted menu supply company. -He edited the old menu, exchanged foods items, and moved the dietician's signature to the menu he created and sent to the facility on 03/31/26 because the state survey was being conducted at the facility.	D 291		
D 316	10A NCAC 13F .0905 (c) Activities Program	D 316		

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D 316	Continued From page 6 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have a current activity calendar posted in the facility.	D 316		

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D 316	Continued From page 7 The findings are: Observations throughout the facility during initial tour on 03/31/26 beginning at 9:14am and continuing until 10:15am revealed there was no activity calendar posted for March 2026. Interview with a resident on 03/31/26 at 9:14am revealed: -There were not a lot of activities to do in the facility. -They needed to have more activities made available to them. -She did not know what was planned for today because there was not an activity calendar posted. Interview with a second resident on 03/31/26 at 9:41am revealed: -There was an activity calendar posted earlier in the month but it had been taken down. -There weren't a lot of activities, but they did have singing and preaching sometimes. Interview with a third resident on 03/31/26 at 9:44am revealed: -There was an activity calendar that had been posted for March 2026, but it had been taken down a few days ago. -She did not have access to a smaller calendar, so she did not know what the planned activities of the day were. Interview with the Manager on 03/31/26 at 12:03pm revealed: -They currently did not have an activity director. -She was currently taking a class to receive her activity director certification but would not be finished until June 2026. -There was usually an activity calendar posted	D 316		

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D 316	Continued From page 8 but she had taken it down yesterday. -She did not keep a copy of past activity calendars. -She was responsible for developing and posting the activity calendar. Interview with the Administrator on 04/01/26 at 9:01am revealed: -The monthly activity calendar should be posted by the 1st day of the month and remain posted throughout the entire month. -They currently did not have an activity director, but the Manager and the personal care aides (PCAs) were responsible for carrying out activities. -The Manager was responsible for developing and posting the activity calendar.	D 316		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews, the facility failed to protect resident's rights related to staff using profanity around residents. The findings are: Interview with a resident on 03/31/26 at 9:44am revealed: -She often heard staff use profanity when they talked to each other in the hallway. -She had asked the staff to stop multiple times	D 338		

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but was told by staff to mind her own business.
-Cursing bothered her and she did not like hearing it.

Interview with a medication aide (MA) on 03/31/26 at 11:59am revealed:
-She may have a "slip-up" and "cuss every once in a while" when she was talking with other staff.
-She had never intentionally cursed in front of a resident.
-She had never been asked by a resident to stop cursing.

Telephone interview with a second MA on 04/01/26 at 2:16pm revealed:
-She did occasionally use profanity when she was working.
-She let the Manager know when she used profanity.
-The Manager told her to remember where she was and to go outside and take a deep breath.
-She needed to remember when she was inside the facility to put personal matters to the side and concentrate on caring for the residents because the facility was their home.

Interview with the Manager on 03/31/26 at 12:03pm revealed:
-Some of the residents complained about hearing some of the staff use profanity when the staff were talking to each other.
-She spoke with staff and explained they needed to be professional and not use profanity inside the facility.

Interview with the Administrator on 04/01/26 at 9:01am revealed:
-Profanity use was never acceptable by staff inside the facility.
-Staff should be respectful of the rights of the

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D 338	Continued From page 10 residents.	D 338		
D 612	10A NCAC 13F .1801(c) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection prevention and control policies and procedures, and when issued, guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat that have been issued in writing by the North Carolina Department of Health and Human Services or local health department. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure recommendations and guidelines established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during an outbreak of the coronavirus (COVID-19) related to 6 of 23 residents who had tested positive not being confined to their rooms and allowing a medication	D 612		

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aide to administer medication who had test positive for COVID-19 and was symptomatic.

The findings are:

Observation of the exterior door of the facility on 03/31/26 at 8:57am revealed a handwritten message "We have COVID in the building. Masks are available."

Observation inside the facility on 03/31/26 at 8:58am revealed there was a table set up with hand sanitizer and face masks.

Review of the facility's Infection Control Policy dated November 2011 revealed:
-There was no specific guidance for infection control or prevention during a communicable disease outbreak.
-The facility did not have a COVID-19 policy for staff to follow.

Review of the CDC Infection Control guidance related to COVID dated 06/24/24 revealed:
-Eliminate exposure by shielding patients from infected individuals.
-Limit transport and movement of the patient outside of the room for medical essential purposes.
-Ideally, the patient should have a designated bathroom.

Review of the NC DHHS guidance to healthcare providers and facilities dated 09/18/25 revealed:
-Health Care Personnel with a mild suspected or confirmed viral respiratory infection should be restricted from work until at least 3 days have passed from symptom onset or their first positive respiratory virus test if asymptomatic throughout their infection, they have been fever-free for at

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least 24 hours without the use of fever-reducing medication, symptoms are improving, and they feel well enough to return to work.
-The first positive test is day 0, making the first possible day of return to work on day 4.

Interview with the Manager on 03/31/26 at 8:58am revealed:
-On 03/27/26, one of the residents was more confused than usual and was sent out to the hospital where it was discovered he was COVID positive.
-The current census was 23.
-There were 5 additional residents who had tested positive for COVID since 03/27/26.

Observation of the Manager on 03/31/26 at 8:58am revealed she was not wearing a mask.

Observation of a resident identified by the Manager as COVID positive on 03/31/26 at 9:18am revealed:
-He was sitting in the living room eating breakfast at a table.
-There was a second resident present in the living room who was identified by the Manager as not having tested positive for COVID.

Interview with a resident identified by the Manager as COVID positive on 03/31/26 at 9:34am revealed:
-She felt "like crap."
-She was COVID positive and 03/31/26 was her 3rd day feeling bad.
-She wore a face mask "at times" because she had two roommates that were not sick.
-She had been going to the living room for every meal with all the other residents who were COVID positive.
-She did not know why they had to eat in the

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living room and wanted to stay in her room for meals.
-"I think it would just be better if I stayed in my room."

Interview with a second resident on 04/01/26 at 9:06am revealed:
-She ate her meals in the living room every day.
-She did not test positive for COVID-19 when all the residents were tested.
-The facility staff moved all the residents who tested positive for COVID-19 to the living room to eat.
-It worried her that she had to eat her meals in the living room along with other residents who had tested positive for COVID-19 and they were not able to wear masks while they were eating.
-She had a lot of health issues and did not want to be exposed or get COVID-19.

Interview with a medication aide (MA) on 03/31/26 at 11:53am revealed:
-She tested positive for COVID on 03/31/26.
-She had a runny nose and chest congestion but no fever.
-She felt bad but was going to work the rest of her shift and then go home.
-The Manager was aware she had tested positive for COVID on 03/31/26.

Interview with the Manager on 03/31/26 at 12:03pm revealed:
-A MA tested positive for COVID on 03/31/26.
-She thought the MA was asymptomatic, so she allowed her to work.
-She told the MA she could go home if she wanted to, but the MA told her that she would finish her shift and then go home.
-All 6 residents who had tested positive for COVID were eating their meals together in the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKE ASSISTED LIVING	125 CAMELLIA GARDEN STREET MORGANTON, NC 28655

(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
D 612	Continued From page 14 living room. -She could not allow the residents to stay in their room because they were at risk for choking and staff needed to be observing them at mealtimes. -She contacted the local health department to inform them of the outbreak on 03/30/26, but did not speak with a representative until 03/31/26. -She did not have designated staff to work with the COVID positive residents. -There was not a designated bathroom for COVID positive residents. -She personally chose not to wear a mask. Interview with the Administrator on 04/01/26 at 9:01am revealed: -She was informed by the Manager on 03/27/26 that two residents had tested positive for COVID. -The residents that were COVID positive should have been quarantined to their room. -The residents that were COVID positive should have had all meals in their rooms on disposable plates, cups, and utensils. -There should have been one bathroom designated for use for COVID positive residents. -She thought they had policies and procedures regarding COVID but she was unable to locate them. -She thought if staff were COVID positive, but asymptomatic, they could work. -She thought if staff were COVID positive and symptomatic, they needed to be out of work for three days. -The Manager should not have allowed the MA who was COVID positive to work. Interview with the Primary Care Provider for all residents at the facility on 04/01/26 at 12:40pm revealed: -He had not been made aware of any residents testing positive for COVID at the facility.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL012045	A. BUILDING: _____ B. WING _____	04/01/2026

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D 612	Continued From page 15 -He would expect a facility staff member to contact him for any resident who tested positive for COVID. -All residents who tested positive should have been confined to their rooms for 5 to 7 days, until they were symptom free. -All residents should be fever free for 24 hours without medication and a negative COVID test before allowing them to be around the other residents. -If COVID positive residents were eating meals together in a common living area, this could allow the virus to spread to other residents and staff. -Staff that tested positive should not be allowed to work whether they had symptoms or not because it put all residents at risk for contracting COVID. -Facility staff should be referring to the local health department for guidelines. Interview with the Infection Control nurse at the local health department on 04/01/26 at 1:45pm revealed: -She was contacted by the facility Manager by phone on 03/30/26 there was an outbreak at the facility. -The call was after she had left work for the day, so she did not get the message until 03/31/26. -She spoke with the facility Manager on 03/31/26 and informed her that all staff needed to wear masks and be extra vigilant about hand hygiene. -The residents who were COVID positive needed to remain in their rooms for 5 to 7 days and retested in 5 to 7 days. -It would be best for all residents if there was a designated bathroom for residents who were COVID positive. -She sent the Manager an informational list provided by the CDC to follow. The facility failed to follow infection control	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL012045	A. BUILDING: _____ B. WING _____	04/01/2026

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D 612	Continued From page 16 guidelines provided by the local health department related to isolating residents who dad tested positive for COVID from residents who had not tested postivie for COVID by allowing them to eat all meals in the common living area and allowing a MA to continue working after testing positive for COVID. The failure of the facility to follow infection control guidelines was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-D-34 on 03/31/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 16, 2026.	D 612		