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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445155 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Dover Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 537 Spring Street Suite 350 Dover, TN 37058 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure food was served under sanitary conditions when 1 of 3 (Cook A) staff members in the kitchen handled residents' food with no gloves on. The facility had a census of 47 with 47 of those residents receiving a tray from the kitchen. The findings include: Review of the undated facility policy titled, Handwashing Procedure for Dining Services, revealed . Hand hygiene continues to be the primary means of preventing the transmission of infection.some situations that require hand hygiene.Before and after eating or handling food.After handling soiled equipment or utensils.After removing gloves.In between glove changes.Between tasks. Observation in the kitchen on 7/21/2025 at 4:50 PM, revealed [NAME] A removed bread from the package without gloves. During an interview on 7/21/2025 at 4:59 PM, the Certified Dietary Manager confirmed that gloves should have been worn to remove the bread from the package. During an interview on 7/22/2025 at 3:00 PM, the Director of Nursing confirmed that staff should not use their bare hand to touch residents' food.</p> |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure proper infection control practices were followed when 1 of 9 staff members Certified Nursing Assistant (CNA) B failed to handle and serve food under sanitary conditions for 2 of 20 (Resident #14 and #45) residents observed during dining, and when 1 of 2 Registered Nurses (RN) C failed to perform hand hygiene for 3 of 5 (Resident #17, #47, and #55) residents observed during medication administration. The findings include: 1. Review of the facility policy titled, .Handwashing/Hand Hygiene . dated October 2023, revealed .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Perform hand hygiene before applying non-sterile gloves .When removing gloves .Perform hand hygiene . Review of the facility policy titled, .Medication Administration, dated 6/21/2017, revealed .Preparing Medication for Administration . Never touch any of the medication with fingers . 2. Random observation during dining on 7/21/2025 at 12:21 PM, revealed CNA B assisted Resident #14 in the dining room, CNA B removed Resident #14's bread with her bare hand to apply mustard to Resident #14's sandwich. Random observation during dining on 7/21/2025 at 12:29 PM, revealed CNA B assisted Resident #45 with his meal and touched the Resident's sandwich her bare hands. The Director of Nursing (DON) informed CNA B that she couldn't touch the Resident's bread. During an interview on 7/22/2025 at 3:00 PM, the DON confirmed that staff should not use their bare hand and touch resident's food when assisting with meals. 3. Observation during medication administration on the A Hall on 7/22/2025 at 7:56 AM, revealed RN C prepared Resident #17's medications and donned gloves without performing hand hygiene, administered the medication, doffed (removed) gloves and did not perform hand hygiene. Observation during medication administration on the A Hall on 7/22/2025 at 8:16 AM, revealed RN C prepared Resident #55's medications, dropped multiple medications on top of the medication cart, picked up the medications with his bare hands, and placed the medications in the medicine cup. Observation during medication administration on A Hall on 7/22/2025 at 8:31 AM, revealed RN C prepared Resident #47's medication, dropped medication on top of the medication cart, picked up the medications with his bare hand and placed in the medicine cup, donned gloves, administered the medication, doffed gloves, and returned to medication cart without performing hand hygiene. During an interview on 7/22/2025 at 8:38 AM, RN C confirmed hand hygiene should have been performed before and after administering medications. RN C confirmed that he should not have picked up the medications with his bare hands. During an interview on 7/23/2025 at 8:50 AM, the DON confirmed medication should not be touched with bare hands and hand hygiene should have been performed before preparing medication, and when gloves are donned and doffed.</p> | | |