

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Clovis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 North Norris Street Clovis, NM 88101	

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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure residents and/or their representatives were informed in advance of what medications they received and understood the reasons, risks, and benefits of the medications for 1 (R #3) of 5 (R #1, R #3, R #5, R #9 and R #27) residents reviewed for unnecessary medications. If the residents or their representatives are not informed of the risks and benefits of the medication or treatment alternatives, they are not able to make informed decisions regarding residents' care. The findings are:A. Record review of R #3's physician's orders revealed the following: 1. An order for Lorazepam tablet (anti-anxiety medication), 0.5 milligrams (mg). Give one tablet by mouth two times a day for anxiety. Start date: 09/09/25,2. An order for Hydroxyzine HCL tablet (antihistamine; medications used to treat anxiety, allergic reactions and as a sedative before and after surgery) 25 milligrams. Give one tablet by mouth two times a day for anxiety. Start date: 10/22/25.B. Record review of R #3's medical record revealed there were no consents for the use of Lorazepam and Hydroxyzine. C. On 12/05/25 at 1:22 pm, during an interview with the Director of Nursing (DON), she confirmed staff did not obtain the consent form for the use of Lorazepam and Hydroxyzine for R #3 prior to the use of medication. The DON confirmed that staff are expected to complete the psychotropic medication (psychotropic medication; any drug that affects brain activities associated with mental processes and behavior) consent form prior to the resident starting psychotropic medications and did not.

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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception) unless the medication was medically necessary for 3 (R #3, R #9 and R #60) of 5 (R #1, R #3, R #5, R #9, and R #60) residents reviewed for unnecessary medications, when staff failed to ensure psychotropic medications were necessary to treat a specific condition as diagnosed and documented in the clinical record. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The findings are:R#3A. Record review of R #3 admission Record revealed R #3 was admitted to the facility on [DATE] with the following diagnoses:2. Gastroenteritis and colitis (Gastroenteritis; inflammation of the stomach and intestines; Colitis; inflammation specifically of the large intestine)3. Hypotension (low blood pressure)4. Chronic pain5. Constipation6. Paraplegia (paralysis affecting the lower half of the body)7. Major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significance impairment in daily life.) B. Record review of R #3's physician orders revealed the following:1. An order for Melatonin Oral Tablet (hypnotic; drugs whose primary function is to induce sleep) 3 milligrams (MG). Give 1 tablet by mouth at bedtime for insomnia. Start date 07/08/25. 2. An order for Tetrabenazine Oral Tablet 12.5 milligrams (MG). Give 1 tablet by mouth three times a day for Tardive Dyskinesia. Start date 07/13/25. R #9C. Record review of R #9's admission record revealed R #9 was admitted to the facility on [DATE] with the following diagnoses: 1. Depression (a mood disorder that causes persistent feeling of sadness and loss of interest), 2. Insomnia (sleep disorder making it hard to fall or stay asleep)3. Cerebral infarction (ischemic stroke; happens when a blood clot blocks an artery in the brain, cutting off oxygen and causing brain cells to die)4. Hyperlipidemia (high levels of fat in your blood) D. Record review of R #9's physician order revealed an order for Hydroxyzine HCl Tablet (antihistamine; medications used to treat anxiety, allergic reactions and as a sedative before and after surgery) 50 milligrams (MG). Give 1 tablet by mouth two times a day for anxiety/agitation Start date 12/02/25. R #60E. Record review of R #60's admission record revealed R #60 was admitted to the facility on [DATE] with the following diagnoses. 1. Respiratory Failure (low blood oxygen)2. Anxiety Disorder (mental disorder characterized by intense, excessive, and persistent worry or fear that interferes with daily life.)3. History Of Ischemic Attack (ischemic stroke; happens when a blood clot blocks an artery in the brain, cutting off oxygen and causing brain cells to die)4. Dissociative Identity Disorder (a complex mental health condition, where a person's identity fragments into two or more distinct personalities)5. Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs)6. Major Depressive Disorder (a mental heal disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.) F. Record review of R #60's physician order revealed an order for Depakote (anticonvulsant medication) Oral Capsule 125 MG. Give 1 capsule by mouth three times a day for Dementia with behavioral disturbance. Start date 07/22/25 G. On 12/05/25 at 1:22 pm, during an interview with the Director of Nursing (DON) she confirmed the following:1. R #3 does not have a diagnosis for insomnia,2. R #3's indicated use of Melatonin is for insomnia, 3. R #3 does not have a diagnosis listed for Tardive Dyskinesia,4. R #3's indicated use of Tetrabenazine is for Tardive Dyskinesia, 5. R #9 does not have a diagnosis for anxiety, 6. R #9's indicated use of Hydroxyzine is for anxiety, 7. R #60 does not have a diagnosis for dementia, 8. R #60's indicated use of Depakote is for dementia. The DON confirmed medications should be documented to treat specific conditions as diagnosed and were not.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to provide a Facility Initiated Report (mandatory self-initiated facility report of an incident) and a five day follow up report to the State Survey Agency (SSA) for 1(R#7) of 1 (R #7) resident reviewed for incidents when staff failed to report the following incidents:1) Unwitnessed fall with injury for R #7.2) Injury of left hand for R #7 within two hours of becoming aware of the injuries.This deficient practice is likely to result in the State Survey Agency (SSA) not being aware of facility incidents and being unable to assure residents safety. The findings are:A. Record review of R #7's nursing documentation, dated 09/16/25 at 6:13 am, revealed R #7 reported falling into wheelchair. Noted swelling, mild deformity (a minor physical abnormality in the shape, size, or alignment of a body part), bruising, pain rated 6/10 (pain scale; a rating zero to ten where zero is no pain and ten is the worst pain possible) to left hand.B. Record review of the facility's complaint intake report dated 10/10/25 revealed R #7 had an unwitnessed fall on 09/16/25 resulting in a broken finger. C. Record review of the State Survey Agency's (SSA) Intake Report indicated no facility report was received on 09/16/25 for an unwitnessed fall with injury to R #7's left hand. D. Record review of the State Survey Agency's (SSA) Follow up Report dated 12/04/25 revealed the facility follow up report was completed 79 days after R #7 had an unwitnessed fall on 09/16/25. E. On 12/04/25 at 10:15 am during an interview with the Director of Nursing (DON), she stated any fall with significant injury should have been reported right away and it was not. DON stated they should have done an in-house report to the state when it was brought to their attention of the unwitnessed fall on 09/16/25 within two hours.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to complete an accurate Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment for 1 (R #8) of 1 (R #8) resident reviewed for assessments. This deficient practice could likely result in the residents' preferences and care needs not being met. The findings are:A. Record review of R #8's admission Record revealed R #8 was admitted to the facility on [DATE] with the following diagnoses:1. Adult failure to thrive (a syndrome that describes a decline characterized by weight loss, decreased appetite, poor nutrition, inactivity and often accompanied by dehydration, depressive symptoms, and impaired immune function, among others.),2. Chronic heart failure (a long-term condition where the heart muscle becomes too weak or stiff to pump enough blood to meet the body's needs),3. Need for assistance with personal care. B. Record review of R #8's MDS assessment dated [DATE], section H revealed R #8 does not use an external catheter (a non-invasive medical device used to collect urine from outside the body). C. On 12/01/25 at 11:53 am during a random observation of R #8's room revealed a canister with what appeared to be urine collecting. D. On 12/01/25 at 12:15 pm, during an interview with R #8, she confirmed the canister was connected to an external catheter that she utilizes. R #8 stated that she has used the external catheter since before she was admitted to the facility. E. On 12/05/25 at 1:13 pm during an interview with the Director of Nursing (DON), she confirmed that R #8 does utilize an external catheter. The DON confirmed that the external catheter was not included in R #8's MDS assessment and stated it should be included in the MDS assessment.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create a baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #67) of 1 (R #67) resident reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: A. Record review of R #67's admission Record revealed R #67 was admitted to the facility on [DATE] with the following diagnoses:1. Partial intestinal obstruction (a person's intestines are impacted with stool), 2. Essential hypertension (HTN; high blood pressure),3. Colostomy [a surgical procedure in which the colon is connected to the abdominal wall and an opening (stoma) is created in the abdominal wall created to allow waste to leave the body] status,4. Encounter for surgical aftercare following surgery on the digestive system (need for assistance after abdominal surgery). B. Record review of R #67's Electronic Health Record revealed there was no baseline care plan. C. On 12/05/25 at 12:50 PM during an interview with the Director of Nursing (DON), she confirmed the baseline care plan was not completed and should have been.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement an accurate, comprehensive care plan for 1 (R #8) of 3 (R #8, R #12, and R #25) residents reviewed for care plans when staff failed to include R #8's use of an external catheter (external catheter (a non-invasive medical device used to collect urine from outside the body) and interventions needed to care for R #8 and the external catheter. This deficient practice could likely result in an increase in infections and other health concerns. The findings are: A. Record review of R #8's admission Record revealed R #8 was admitted to the facility on [DATE] with the following diagnoses:1. Adult failure to thrive (a syndrome that describes a decline characterized by weight loss, decreased appetite, poor nutrition, inactivity and often accompanied by dehydration, depressive symptoms, and impaired immune function, among others.),2. Chronic heart failure (a long-term condition where the heart muscle becomes too weak or stiff to pump enough blood to meet the body's needs),3. Need for assistance with personal care. B. On 12/01/25 at 11:53 am during a random observation of R #8's room revealed a canister with what appeared to be urine. C. On 12/01/25 at 12:15 pm, during an interview with R #8, she confirmed the canister was connected to an external catheter that she utilizes. R #8 stated that she has used the external catheter since before she was admitted to the facility. D. Record review of R #8's electronic health record revealed no care plan or intervention in place for R #8's use of an external catheter. E. On 12/05/25 at 1:13 pm during an interview with the Director of Nursing (DON), she confirmed R #8 does utilize an external catheter. The DON confirmed the facility failed to develop and implement a care plan that includes R #8's external catheter use. The DON stated that she expects every resident that utilizes a catheter whether it's external or not to have a care plan that includes needed interventions.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 6 (R #3, R #4, R #7, R #24, R #27 and R #48) of 9 (R #1, R #3, R #4, R #5, R #7, R #9, R #24, R #27 and R #48) residents reviewed when staff failed to:1. Revise R #3's care plan to include use of psychotropic drugs (drugs that affect a person's mental state),2. Update R#4's care plan to remove the use of Voltaren (medication used for pain),3. Revise R#7's care plan to include appropriate interventions for falls.4. Revise R #24's discharge goals in the care plan to include current discharge goals. 5. Revise R #27's care plan to include the current size of bed rails.6. Revise R#48's care plan to remove the use of a wander guard (wearable device that tracks movement.)These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are:R#3A. Record review of R #3's admission Record revealed R #3 was admitted to the facility on [DATE] with the following diagnoses:1. Anxiety (feelings of fear or apprehension),2. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),3. Hypotension (low blood pressure),4. Chronic pain,5. Constipation,6. Paraplegia (paralysis affecting the lower half of the body),7. Major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significance impairment in daily life).B. Record review of R #3's physician order revealed an order for Melatonin Oral Tablet (hypnotic; drugs whose primary function is to induce sleep) 3 milligrams (MG). Give 1 tablet by mouth at bedtime for insomnia. Start date 07/09/25,C. Record review of R #3's care plan revised on 12/01/25 revealed the following:1. R #3 is at risk for complications related to the use of psychotropic drugs medications Mirtazapine (antidepressant), Sertraline (antidepressant), Buspirone (antianxiety), Lorazepam (antianxiety), Hydroxyzine (antihistamine used to treat anxiety) and Tetrabenazine (antipsychotic).2. The care plan does not contain the use of Melatonin.R #4D. Record review of R #4's admission record revealed R #4 was admitted into the facility on [DATE] with the following diagnoses:1. Chronic pain syndrome (long-lasting pain that significantly impacts life), 2. Chronic obstructive pulmonary disease, unspecified (ongoing lung condition caused by damage to the lungs),3. Essential (primary) hypertension (common form of high blood pressure),4. Depression, unspecified,5. Atherosclerotic heart disease of native coronary artery without angina pectoris (progressive condition characterized by the accumulation of lipids, inflammatory cells, and fibrous elements within the arterial walls).E. Record review of R #4's physician orders revealed a discontinued order for Voltaren Gel 1% with a discontinued date (DC) of 09/19/25.F. Record review of R #4's care plan revised 11/25/25 revealed an intervention for Voltaren gel to apply as ordered with initiated date of 08/22/25.R #7G. Record review of R #7's admission record revealed R #7 was admitted into the facility on [DATE] with the following diagnoses:1. History of falling,2. Lack of coordination (inability to make smooth, controlled movements), 3. Unspecified cirrhosis of liver (chronic liver disease characterized by the replacement of healthy liver tissue with scar tissue, leading to liver failure),4. Muscle weakness (generalized),5. Periorbital cellulitis (bacterial infection that causes swelling in the skin around your eye).H. Record review of R #7's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 11/22/25, revealed the following:1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 05, severe cognitive impairment.2. R #7 has had falls since being admitted to the facility.I. Record review of R #7's care plan initiated on 02/14/25 revealed the following:1. R #7 is at risk for falls.2. R #7's care plan was revised to include falls for 09/18/25, 10/5/25, 10/10/25, 10/21/25, 11/1/25,</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/6/25, 11/18/25 however, R #7's care plan does not include interventions revised to ensure the safety of R #7 after potential risks related to falls.R #24J. Record review of R #24's admission record revealed R #24 was admitted to the facility on [DATE] with the following diagnoses:1. Stable burst fracture of unspecified lumbar vertebra (a serious spinal injury where the vertebral body is compressed and then fractures into multiple pieces),2. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),3. Depression,4. Parkinsonism (an umbrella term that refers to a group of conditions characterized by slowed movement, rigidity, and tremors).K. Record review of R #24's care plan revised on 04/15/25 revealed the following Focus areas:1. R #24 is a long-term resident with no plans for discharge.2. R #24's goal is to increase ADL (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) status and return home with family. R #27L. Record review of R #27's admission record revealed R #27 was admitted to the facility on [DATE] with the following diagnosis1. Hemiplegia (complete paralysis) and Hemiparesis (weakness) following Cerebral Infarction (stroke) affecting Left non-dominant sideM. Record review of R #27's most recent bed rail assessment dated [DATE] revealed bed rail recommendation of quarter size rails on left and right upper sides of beds.N. Record review of R #27's physician order revealed an order dated 09/23/24 for half size bed rails as an enable for turning and repositioning in bed.O. Record review of R #27's care plan revised on 11/19/25 revealed R #27 uses half-sized bed rails on each upper side of the bed for mobility.P. On 12/02/25 at 9:20 am during a random observation of R #27 room revealed quarter size bed rails on the left and right upper side of the bed.Q. On 12/02/25 at 9:45 am during an interview with R #27, she stated she uses the bed rails to help her reposition herself while lying in bed.R. On 12/4/25 at 9:16am during an interview with Registered Nurse (RN) 2, she confirmed the rails on R #27's bed are quarter size rails.R #48S. Record review of R #48's admission record revealed R #48 was admitted into the facility on [DATE] with the following diagnoses:1. Unspecified severe protein-calorie malnutrition (occurs when an individual does not consume enough protein and calories, leading to significant muscle and fat loss, and impaired bodily functions).2. Acute and chronic respiratory failure with hypoxia (respiratory failure when you don't have enough oxygen in your blood).3. Cachexia (condition that causes significant weight loss and muscle loss).4. Chronic diastolic (congestive) heart failure.T. Record review of R #48's physician record revealed a discontinued order for wander guard with a discontinued date (DC) of 10/07/25.U. Record review of R #48's care plan revised on 11/12/25 revealed an intervention for wander guard in place with initiated date of 08/12/25.V. On 12/05/25 at 1:22pm, during an interview with the Director of Nursing (DON), she confirmed the following:1. The care plan for R #3 should have been revised to include use of melatonin as a psychotropic drug and was not.2. R #4 does not have an active order for Voltaren Gel. R#4's care plan should have been revised to remove the use of Voltaren gel and was not.3. Fall interventions that are in place for R #7 are not appropriate interventions and do not meet her expectations.4. R #24's care plan was not revised to include her current discharge goals.5. R #27 uses quarter size bed rails on each side of her bed. The care plan for R #27 should have been revised to include the use of current size bed rails and was not.6. R #48 does not have an active order for a wander guard. R#48's care plan should have been revised and was not.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, transfers, toileting, and eating) assistance for transfers (assisting a resident from one place such as a bed to another place such as a wheelchair) for 1 (R #50) of 3 (R #27, R #50, and R #60) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: A. Record review of R #50's admission record revealed R #50 was admitted to the facility on [DATE] with the following diagnoses: 1. Acute respiratory failure with hypoxia (a medical condition where a sudden decrease in oxygen levels in the blood is due to the lungs' inability to exchange gases), 2. Morbid (severe) obesity, 3. Chronic obstructive pulmonary disease (COPD; lung disease). B. Record review of R #50's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 10/08/25, revealed the following: 1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 15; Cognitively Intact. 2. R #50 is dependent (staff does all of the effort) on staff for toileting hygiene, showering or bathing, and all transfers from bed to wheelchair. C. On 12/02/25 at 8:52 am during an interview with R #50, she stated she cannot get out of bed when the facility is short staffed. R #50 stated this last occurred on 11/24/25, she was able to remember the date because she documented a note on her phone. R #50 stated the Director of Nursing (DON) told her on that date that the facility was short staffed so if R #50 would need to stay in bed or stay in her wheelchair until 9:00 pm or 10:00 pm that night because that is when staff would be able to transfer her again. R #50 said it hurts to stay in her wheelchair for that long, so she had to stay in bed. D. On 12/05/25 at 1:05 pm during an interview with the Director of Nursing (DON), she stated that she does not remember having that conversation with R #50 but confirmed that it does take extra people to get R #50 out of and into her bed because she uses a mechanical lift (a device designed to help staff move a resident from one place to another within a room or from one position to another) for all transfers.</p>		

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NAME OF PROVIDER OR SUPPLIER Clovis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 North Norris Street Clovis, NM 88101	
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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident with an external catheter (a non-invasive device worn over the genitals) had an order that demonstrated that a catheter was necessary, what type of catheter was needed, and how to care for the catheter for 1 (R #8) of 1 (R #8) resident reviewed for catheter use. This deficient practice could likely result in an increased and unnecessary risk of infections for residents. The findings are: A. Record review of R #8's admission Record revealed R #8 was admitted to the facility on [DATE] with the following diagnoses:1. Adult failure to thrive (a syndrome that describes a decline characterized by weight loss, decreased appetite, poor nutrition, inactivity and often accompanied by dehydration, depressive symptoms, and impaired immune function, among others.),2. Chronic heart failure (a long-term condition where the heart muscle becomes too weak or stiff to pump enough blood to meet the body's needs),3. Need for assistance with personal care.B. On 12/01/25 at 11:53 am during a random observation of R #8's room revealed a canister with what appeared to be urine. C. On 12/01/25 at 12:15 pm, during an interview with R #8, she confirmed the canister was connected to an external catheter that she utilizes. R #8 stated that she has used the external catheter since before she was admitted to the facility. D. Record review of R #8's current medical orders revealed no order for the use of a catheter, the type of catheter that is needed, or the care that the catheter requires.E. Record review of R #8's electronic health record revealed no care plan or intervention in place for R #8's use of an external catheter.F. Record review of R #8's MDS assessment dated [DATE], section H revealed R #8 does not use an external catheter.G. On 12/05/25 at 1:13 pm during an interview with the Director of Nursing (DON), she confirmed R #8 does utilize an external catheter and should have an order and care plan with interventions in place.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to obtain physician orders and informed consent prior to installation of bed rails for 2 (R # 3 and R #5) of 5 (R #3, R #5, R #9, R #27 and R #60) resident reviewed for accidents. This deficient practice could result in the physician and the resident not knowing the needs, risks and benefit of bed rails. The findings are:R #3A. Record review of R #3 admission Record revealed R #3 was admitted to the facility on [DATE], with the following diagnoses:1. Spondylolysis (a stress fracture in a small bone), cervical region (neck area of the spine),2. Osteoarthritis (degenerative joint disease where the protective cartilage cushioning your bones wears down over time),3. Reduced Mobility (movement is limited), 4. Muscle weakness,5. Paraplegia (paralysis affecting the lower half of the body).B. Record review of R #3's bed rail assessment dated [DATE] revealed a recommendation for quarter size bed rails on the left and right upper sides of the bed.C. Record review of R #3's Electronic Health Record (EHR) revealed the following:1. There was no physician order for bed rails.2. There was no informed consent.D. On 12/02/25 at 12:10pm during a random observation of R #3's room, revealed quarter size bed rails on the right and left upper sides of R #3's bed.E. On 12/02/25 at 12:14pm during an interview with R #3, he confirmed he uses the bed rails for repositioning.R #5F. Record review of R #5's admission record revealed R #5 was admitted to the facility on [DATE] with the following diagnoses:1. Sciatica (pain, numbness, or weakness radiating along your lower back down through your buttock and leg), left side,2. Muscle Weakness,3. Abnormalities of Gait and Mobility (a significant deviation from normal walking or movement), 4. Lack of Coordination.G. Record review of R #5's bed rail assessment dated [DATE] revealed a recommendation for quarter size bed rails on the left and right upper sides of the bed.H. Record review of R #5's Electronic Health Record (EHR) revealed the following:1. A physician order for quarter size bed rails as an enabler for turning and repositioning dated 07/10/25.2. There was no informed consent.I. On 12/01/25 at 11:53am during a random observation of R #5's room, revealed quarter size bed rails on the right and left upper sides of the R #5's bed.J. On 12/01/25 at 11:53 pm during an interview with R #5, she confirmed she uses the bed rails for repositioning.K. On 12/05/25 at 1:22 pm during an interview with the Director of Nursing (DON), she confirmed the following:1. R #3 uses quarter size bed rails on the right and left upper sides of his bed.2. R #3 does not have a physician order for bed rails and should.3. R #3 does not have an informed consent and should.4. R #5 uses quarter size bed rails on the right and left upper sides of her bed.5. R #5 does not have an informed consent and should.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on observation, record review, and interview, the facility failed to maintain appropriate staffing levels to meet the needs of the 1 (R #8) of 2 (R #8 and R #27) residents reviewed for staffing. This deficient practice could likely result in residents not receiving the care and service needed while in the facility. The findings are: A. Record review of facility PPD (per patient day; staffing ratio posted daily) log revealed a staffing ratio of 2.32 (a calculation of staff hours based on the number of residents in the facility; standard average ratio is 2.5 to 3.48) on 11/24/25. Cross reference tag F-690</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation and interview, the facility failed to post nurse staffing data on a daily basis at the beginning of the shift that included the following: 1. Facility name. 2. The current date. 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: 1. Registered nurses. 2. Licensed practical nurses. 3. Certified nurse aides. 4. Resident census. This deficient practice has the potential to affect all 62 residents as identified by the census provided by the Administrator on 12/01/25 and could likely result in residents and visitors not having the staffing information readily available. The findings are: A. On 12/01/25 at 11:04 AM, during observation of the main entrance, the nurse staffing data was dated 11/30/25 and was not posted for the current day. B. On 12/01/25 at 11:10 AM, during an interview with the Administrator, he confirmed the nursing staff data should be posted daily and was not.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by ensuring medications have an adequate indication of use and ensuring indication of use is based off of the residents' current diagnosis for 5 (R #1, R #3, R #5, R #9, and R #60) of 7 (R #1, R #3, R #5, R #9, R #11, R #40 and R #60) residents reviewed for unnecessary medications. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The findings are:R #1A. Record review of R #1's admission Record revealed R #1 was admitted to the facility on [DATE] with the following diagnoses:1. Chronic obstructive pulmonary disease (COPD; progressive lung disease that makes it difficult to breathe, irreversible damage to the lungs and airways).2. Hypertension (high blood pressure).3. Hyperlipidemia (high cholesterol)B. Record review of R #1's physician records revealed an order for Aspirin oral tablet 81 milligrams (MG). Give 1 tablet by mouth one time a day for preventative (does not identify use or need of medication). Start date 11/19/25.C. On 12/05/25 at 1:22 pm, during an interview with the Director of Nursing (DON), she confirmed R #1 has an order for aspirin. The order for aspirin does not indicate what the medication is used for and should. She confirmed preventative is not an appropriate indication of use for medication and does not meet her expectations.R #3A. Record review of R #3 admission Record revealed R #3 was admitted to the facility on [DATE] with the following diagnoses:2. Gastroenteritis and colitis (Gastroenteritis; inflammation of the stomach and intestines; Colitis; inflammation specifically of the large intestine),3. Hypotension (low blood pressure),4. Chronic pain.5. Constipation.6. Paraplegia (paralysis affecting the lower half of the body).7. Major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significance impairment in daily life).E. Record review of R #3's physician orders revealed the following:1. Acidophilus Probiotic (dietary supplement) oral tablet. Give 2 capsules by mouth two times a day for probiotic. Start Date 07/09/25.2. The order does not contain the dosage of the medication.F. On 12/05/25 at 1:22 pm, during an interview with the DON, she confirmed1. R #3 has an order for Acidophilus Probiotic. 2. The order for Acidophilus Probiotic does not indicate what the medication is used for and should. She confirmed probiotic is not an appropriate indication of use for medication.3. The order should contain the dosage of medication4. The order and instructions should have the same form of medication (capsule vs tablet) being delivered.The DON stated the order for R #3's Acidophilus Probiotic does not meet her expectations.R #5G. Record review of R #5's admission record revealed R #5 was admitted to the facility on [DATE] with the following diagnoses:1. Emphysema (a chronic lung disease where tiny air sacs (alveoli) in the lungs become damaged and lose elasticity),2. Anemia (a common blood disorder where your body lacks enough healthy red blood cells to carry sufficient oxygen to tissues),3. Bell's Palsy (temporary condition causing weakness or paralysis on one side of the face due to inflammation of the facial nerve),4. Cerebral ischemic attack (a temporary blockage of blood flow to the brain),H. Record review of R #5's physician orders revealed the following:1. Potassium Chloride Extended Release (ER) Oral Tablet 8 milliequivalent (MEQ). Give 1 tablet by mouth two times a day for hypokalemia. Start Date 11/18/25.2. Atorvastatin Calcium Tablet 40 milligrams (MG). Give 1 tablet by mouth at bedtime for hyperlipidemia. Start Date 07/09/25.3. Colace Capsule 100 milligrams (MG). Give 1 capsule by mouth two times a day for Constipation. Start date 07/09/25.4. Aspirin Tablet 81 milligrams (MG). Give 1 tablet by mouth one time a day for prophylactic (does not identify use or need of medication). Start Date 07/10/25.5. Naloxone hydrochloride (HCl) Liquid 4 milligrams (MG)/0.1milliliters (ML). Give 1 spray alternating nostrils every two minutes as needed for sign of opioid overdose. May be repeated every two to</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>three minutes for unresponsiveness or difficulty breathing, until individual is breathing rate is greater than ten. Initiate emergency medical response protocol (e.g., call 911) and transfer to the hospital. Start Date 10/29/25.6. R #5 does not have current orders for opioid medications.1. On 12/05/25 at 1:22 pm, during an interview with the Director of Nursing (DON), she confirmed the following:1. R #5 does not have a diagnosis of hypokalemia, hyperlipidemia, and constipation.2. R #5's medications should be indicated to use as it relates to her diagnosis and does not.3. R #5 has an order for aspirin. The order for aspirin does not indicate what the medication is used for and should. She confirmed prophylactic is not an appropriate indication of use for medication does not meet her expectations.4. R #5 is not currently taking opioids and should not have an order for Naloxone. R #9J. Record review of R #9's admission record revealed R #9 was admitted to the facility on [DATE] with the following diagnoses:1. Depression (a mood disorder that causes persistent feeling of sadness and loss of interest),2. Insomnia (sleep disorder making it hard to fall or stay asleep),3. Cerebral infarction (ischemic stroke; happens when a blood clot blocks an artery in the brain, cutting off oxygen and causing brain cells to die),4. Hyperlipidemia (high levels of fat in your blood).K. Record review of R #9's physician orders revealed the following: 1. Cetirizine HCl Oral (allergy medication) Tablet 10 milligrams (MG). Give 1 tablet by mouth one time a day for allergies. Start Date 10/22/25.2. Cephalexin Oral Capsule (antibiotic medication) 500 milligrams (MG). Give 1 capsule by mouth three times a day for urinary track infection (UTI) for 7 Days. Start date 11/28/25.3. Aspirin Oral Tablet Chewable 81 MG. Give 1 tablet by mouth one time a day for preventative. Start Date 10/22/25.L. On 12/05/25 at 1:22 pm, during an interview with the Director of Nursing (DON), she confirmed the following:1. R #9 does not have a diagnosis listed of allergies and UTI.2. R #9's medications should be indicated to use as it relates to her diagnosis and does not.3. R #9 has an order for aspirin. The order for aspirin does not indicate what the medication is used for and should. She confirmed preventative is not an appropriate indication of use for medication and does not meet her expectations.R #60M. Record review of R #60's admission record revealed R #60 was admitted to the facility on [DATE] with the following diagnoses.1. Respiratory Failure (low blood oxygen)2. Anxiety Disorder (mental disorder characterized by intense, excessive, and persistent worry or fear that interferes with daily life,)3. History Of Ischemic Attack (ischemic stroke; happens when a blood clot blocks an artery in the brain, cutting off oxygen and causing brain cells to die)4. Dissociative Identity Disorder (a complex mental health condition, where a person's identity fragments into two or more distinct personalities)5. Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs)6. Major Depressive Disorder (a mental heal disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.)N. Record review of R #60's physician orders revealed the following:1. Furosemide Tablet (Diuretic; to treat fluid retention) 40 milligrams (MG). Give 1 tablet by mouth one time a day for bilateral lower edema. Start Date 11/18/25.2. Aspirin Tablet Chewable 81 milligrams (MG). Give 1 tablet by mouth one time a day for prophylactic. Start Date 04/08/25,O. On 12/05/25 at 1:22 pm, during an interview with the Director of Nursing (DON), she confirmed the flowing:1. R #60 does not have a diagnosis of edema.2. R #60's medications should be indicated to use as it relates to her diagnoses and does not.3. R #60 has an order for aspirin. The order for aspirin does not indicate what the medication is used for and should. She confirmed prophylactic is not an appropriate indication of use for medication and does not meet her expectations.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation and interview, the facility failed to ensure safe medication storage practices by not ensuring the following:1. The medication carts were locked while unattended,2. The medical supply storage rooms were kept free of expired medications,3. Personal drinking cups were not kept stored in the medication cart.These deficient practices have the potential to affect all 62 residents as identified by the census provided by the Administrator on 12/01/25. If the facility does not ensure safe storage practices, then residents are at risk for unauthorized persons to have access to medications and adverse effects due to improper storage. The findings are:Medication Carts:A. On 12/02/25 at 8:39 am, during an observation of the facility, the medication cart located near the nurse's station was found unlocked and unattended.B. On 12/02/25 at 8:39 am, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that the medication cart near nursing station was not locked and should be.Medication Storage:C. On 12/04/25 at 9:20 am, during a medical storage observation revealed the following:1. The nurse had her personal drinking cup located in the bottom right-hand drawer of the 100-hall medication cart.2. The East/West Medication Storage room vaccine refrigerator revealed one opened box of five prefilled syringes of Hepatitis B Vaccine (a vaccine given to help prevent against getting Hepatitis B virus) with the expiration date of 05/19/25.D. On 12/04/25 at 9:30 am, during an interview with the DON, she confirmed the vaccines were expired and should be properly disposed of. The DON confirmed there should not be any personal drinks/items on the medication carts due to infection control concerns.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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 observation and interview, the facility failed to ensure food was prepared and served under sanitary conditions when staff failed to: 1. Properly store dishes in sanitary conditions. 2. Properly label food items in the refrigerator. 3. Properly wear hair nets while in the kitchen. These deficient practices are likely to affect all 62 residents listed on the resident census list provided by the Administrator on 12/01/25 and are likely to lead to foodborne illnesses in residents if safe food handling practices are not adhered to and food stored properly. The findings are: A. On 12/01/25 at 11:05 am, an observation of the kitchen revealed Dietary Aid (DA) #1 not wearing a hairnet. B. On 12/01/25 at 11:06 am, during an interview with DA #1, she stated she was brand new employee and was unaware that she always needed a hairnet. C. On 12/01/25 at 11:08 am during an interview with Dietary Manager (DM) #1, she confirmed that DA #1 was not properly wearing the hairnet. She stated her expectation is for all staff to properly wear hairnets while in the kitchen or serving food. D. On 12/01/25 at 11:15 am, an observation of the kitchen revealed what appeared to be dry parmesan cheese and lettuce in the main refrigerator and did not have a label indicating the contents or date it was prepared. E. On 12/01/25 at 11:16 am, during an interview with the Kitchen Director (KD) #1, he confirmed the items in the fridge were not labeled and dated. He stated his expectations are for all items in the fridge to properly be labeled, dated, and stored. F. On 12/01/25 at 11:20 am, an observation of dishes being stored under the kitchen warmers appeared to be stored on top of other dirty containers. G. On 12/01/25 at 11:21 am, during an interview with KD #1, he confirmed the dishes were not stored under sanitary conditions. He stated his expectations would be for all dishes and kitchen equipment to be stored under sanitary conditions.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were updated and accurate for 1 (R 48) of 1(R 48) resident reviewed, when the facility failed to document an admit to Hospice (palliative and supportive services to meet the physical, psychological, social, and spiritual needs of terminally ill residents).order upon admission to facility.This deficient practice is likely to result in residents having an inaccurate medical record, which could result in the residents receiving less than optimal care and treatment. The findings are: A. Record review of R #48's face sheet revealed R #48 was admitted into the facility on [DATE] with the following diagnoses:1. Unspecified severe protein-calorie malnutrition (occurs when an individual does not consume enough protein and calories, leading to significant muscle and fat loss, and impaired bodily functions).2. Acute and chronic respiratory failure with hypoxia (respiratory failure when you don't have enough oxygen in your blood).3. Cachexia (condition that causes significant weight loss and muscle loss).4. Chronic diastolic (congestive) heart failure.B. Record review of R #48's physician telephone order dated 05/02/05 revealed facility staff received an order for R #48 for admit to hospice. C. Record review of R #48's orders revealed no order for admit to hospice. D. On 12/05/25 at 12:55 pm during an interview with the Director of Nursing (DON), she confirmed that there was no active order for Admit to Hospice for R #48. She stated an Admit to order should have been entered on 05/02/25 when R #48 was admitted to facility on Hospice orders.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to implement an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections) by not ensuring Enhanced Barrier (EBP) signs are posted outside of rooms with Personal Protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection). This failed practice has the potential to affect all 62 residents living in the facility as identified by the census provided by the Administrator 12/01/25. These deficiencies place residents at risk of contracting infections, hospitalization, and death. The findings are:A. On 12/01/25 at 10:22 am, during a random observation of the facility, PPE was hanging on the doors outside rooms 100, 205, 306, 307, and 311. Enhanced barrier precaution signs for Rooms 205, 306 and 307 were not posted.B. Record review of the facility's Infection control policies and procedures dated 07/15/25 indicated to refer to Centers for Disease Control and Prevention (CDC).C. Record review of CDC guidelines from CDC website Enhanced Barrier Precautions (EBP) in Nursing Homes. Centers for Disease Control. https://www.cdc.gov/infection-control/Webinar-EBPinNH-Nov2022-Slides-508.pdf on Slide number 28 Communication, revealed the use appropriate and legible signs for precautions, the CDC recommends that EBP signs be displayed outside the door of the room where EBP is required. The sign should indicate the type of precaution and PPE to be used during high-contact resident care activities.D. On 12/05/25 at 11:35 am during an interview with Administrator, she stated signs should be in a place for residents with enhanced precautions.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Clovis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 North Norris Street Clovis, NM 88101	
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)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the medical records contained documentation that each resident received, or was offered the COVID-19 (an acute respiratory disease in humans characterized mainly by fever and cough and capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) vaccinations (treatment with a vaccine to produce immunity to a particular infections disease or pathogen) for 2 (R #4 and R #5) of 5 (R #3, R #4, R #5, R #8, and R #40) residents reviewed for immunizations. This deficient practice could likely result in residents not having the knowledge or opportunity to get needed vaccinations. The findings are: R #4A. Record review of R #4's admission record revealed R #4 was admitted to the facility on [DATE]. B. Record review of R #4's Electronic Health Record (EHR) revealed R #4 did not receive or was offer the COVID vaccination. R #5C. Record review of R #5's admission record revealed R #5 was admitted to the facility on [DATE]. D. Record review of R #5's Electronic Health Record (EHR) revealed R #5 did not receive or was offer the COVID vaccination E. On 12/05/25 at 1:22 pm, during an interview with the Director of Nursing (DON), she confirmed: 1. R #4 did not have record of receiving or being offered the COVID vaccination. 2. R #5 did not have record of receiving or being offered the COVID vaccination.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Clovis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 North Norris Street Clovis, NM 88101	

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure that residents have a safe and functional environment for all 62 residents reviewed. This deficient practice could likely result in residents being injured and living in an environment in poor repair, which would put the residents at risk of unwanted items, including insects and dust particles to come into their living space. The findings are:A. On 12/01/25 at 11:04 am during observation of the facility, there were several holes on the floor near the wall approximately 1.5 inches by 8 inches long. There were no screens or vent covers covering the holes in the floor.B. On 12/01/25 at 11:25 am during an observation of the facility, the handrails throughout the facility were scuffed and scratched.C. On 12/01/25 at 11:58 am during observation and interview with the Maintenance Director (MD) and the Administrator, they confirmed that there were no vent covers in the hallways. They confirmed that the vents were missing while they were replacing the laminate flooring and the scuffed and scratched handrails.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Clovis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 North Norris Street Clovis, NM 88101	
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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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of 12 hours per year for 1 (CNA #2) of 5 (CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5) CNAs reviewed for training. This deficient practice is likely to result in the CNAs not receiving the necessary training to meet the care needs of the residents. The findings are:A. Record review of CNA #2's personnel file revealed CNA #2 was hired on 03/11/20.B. Record review of CNA #2's in-service training transcript report dated 12/05/25 revealed CNA #2 completed five and a half hours of in-service training from 12/06/24 to 12/05/25.C. On 12/05/25 at 10:30 am during an interview with the Payroll Specialist (PS), she stated that she expects all CNAs to complete the required amount of training each year and confirmed that CNA #2 has not.</p>		