

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>205090</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____                       |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/30/2024</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BORDERVIEW REHAB &amp; LIVING CTR</b> |                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>208 STATE STREET</b><br><b>VAN BUREN, ME 04785</b> |                                                                                                                          |                                                                    |  |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                  |                                                                            |  | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    |  |
| {E 000}                                                                      | Initial Comments<br><br>Federal Recertification Survey<br>Date: 4/18/2024<br><br>Borderview Rehab & Living Center, a long term<br>care facility, is in substantial compliance with 42<br>Code of Federal Regulations Part 483.73<br>Requirement for Long Term Care Facilities<br>Emergency Preparedness.                                                                      |                                                                            |  | {E 000}                                                                                        |                                                                                                                          |                                                                    |  |
| {K 000}                                                                      | INITIAL COMMENTS<br><br>Desk Audit For Federal Recertification Survey:<br>Desk Audit Date: 4/30/2024<br><br>Borderview Rehab & Living Center, a Long Term<br>Care Facility, was surveyed to the National Fire<br>Protection Association 101 Life Safety Code 2012<br>Edition as reference on 42 CFR 483.90 (a-d)<br>physical environment and is in substantial<br>compliance. |                                                                            |  | {K 000}                                                                                        |                                                                                                                          |                                                                    |  |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE        |                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | TITLE                                                                                          |                                                                                                                          | (X6) DATE                                                          |  |

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.