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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205090	A. BUILDING _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BORDERVIEW REHAB & LIVING CTR	208 STATE STREET VAN BUREN, ME 04785

(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) COMPLETION DATE
F 000	INITIAL COMMENTS From 5/12/25 to 5/14/25, on-site visits were conducted at Borderview Rehab & Living Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification. It was determined that Borderview Rehab & Living Center was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	See Attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darlene Lavoie RN | TITLE: Assistant Administrator | (X6) DATE: 6/11/25

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.

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary condition for 3of 3 days of survey (5/12/25, 5/13/25, and 5/14/25). Findings: 1. On 5/12/25 at 12:00 p.m., during an observation in the dining room, the surveyor observed the ice/water machine had heavy dust on the side vent panel, the chrome front and drip tray were noted to be coated in a white buildup and the drip tray had peeled coating exposing rusted metal. 2. On 05/13/25 at 2:41 p.m., during a second observation in the dining room the surveyor observed the ice/water machine in the dining room with a white buildup on the front of the machine and the drip tray were noted to be coated in a white buildup and the drip tray had peeled coating exposing rusted metal and the	F 584	See Attached.	

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F 584	Continued From page 2 side vent panel had a heavy amount of dust. On 5/13/25 at 2:53 p.m., a surveyor confirmed the above finding with the Minimum Data Set (MDS) Nurse. 3. On 5/12/25 at 1:10 p.m,. during initial observation of Room 119, Resident #3's (R3) wheelchair arms and wheelchair legs were cracked, creating uncleanable surfaces. 4. On 5/12/25 at 11:39 a.m., during initial observation of Room 120, R2's pole used to hold a feeding nutrition bag, had dirt/debris on the base of the pole and the protective coating was worn off, and R2's oxygen concentrator and filters were dusty/dirty. On 5/13/25 at 3:55 p.m., an Environmental Tour was conducted with the Infection Preventionist in which a surveyor confirmed the above findings. 5. On 5/14/25 at 9:30 a.m., during an observation of the dining room two surveyors confirmed with the Maintenance Supervisor that the tablecloths still had food debris on them from breakfast, the discs under the feet of the ice/water machine were dirty, and the sink had debris around the edges.	F 584	See Attached.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677	See Attached.	

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F 677	Continued From page 3 Based on observations and interviews, the facility failed to provide residents with oral care for 1 of 6 residents observed (Resident #21 [R21]). Finding: On 5/12/25 at 11:45 a.m., during an interview/observation with R21 the surveyor observed that his/her dentures were not clean. They appeared to be caked with an unknown white substance. The resident stated that the only concern he/she has is that they do not brush his/her teeth every day. R21's care plan was reviewed, and the care plan addresses that he/she does need extensive assistance of 1 staff to assist with care and is not able to perform activity of daily living (ADL) independently. On 5/13/25 at 10:26 a.m., during a resident observation it was noted that R21 was sitting in his/her wheelchair on the side of the bed. It was noted that he/she had just been assisted with ADLs. The surveyor observed that his/her dentures/teeth remain with food particles and caked with an unknown white substance and visually dirty. On 5/13/25 at 12:34 p.m., during an interview with Certified Nursing Assistant #1 [CNA1] who was doing whirlpools (wp's) today and had R21 scheduled. Due to medical reasons R21 does not go into the wp and gets a complete bed bath instead. CNA1 stated that she washed him/her up at bedside. The surveyor asked if she assisted him/her with brushing their teeth. She stated, "oh no, I just used mouthwash". The surveyor asked why his/her teeth were not	F 677	See Attached	

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F 677	Continued From page 4 brushed and CNA1 stated, "I meant to go back I just forgot". The surveyor confirmed at this time that R21 was not assisted with oral care.	F 677	See Attached	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure food temperatures were maintained at the proper holding temperature for 1 of 3 meal services observed. (5/12/25, lunch meal). In addition, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 3 days of survey (5/13/25, 5/14/25). Findings:	F 812	See Attached	

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F 812	Continued From page 5 1. On 5/12/25 at 12:10 p.m., a meal service (lunch meal) was observed in the skilled hallway outside the dining room. The food was transported in a portable steamtable to the skilled hallway. The temperatures were taken prior to meal service. The lunch meal was temped, the Steak sandwich was 120 degrees Fahrenheit, the French fries (steak cut) was 120 degrees. The pureed meals were served in divided plates. The surveyor asked what the serving temperatures of the pureed food items should be, the dietary aide was not aware that the pureed meals needed to have temperatures taken. At this time the temperatures were taken, and the temperature of the pureed meat was 122 degrees Fahrenheit. These temperatures were below the required 135-degree Fahrenheit holding temperatures. This was confirmed with the dietary aide who was serving the lunch meal at that time. 2. This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an "Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one-inch (2.54 cm)" and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states "all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils."	F 812	See Attached	

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F 812	Continued From page 6 On 5/13/25 at 2:41 p.m., the surveyor observed the air gap on the ice machine drain line. The drainpipes for the ice machine were pushed into the drainpipe located under the sink. The drain lines did not have the 1-inch air gap as required. On 5/14/25 at 9:30 a.m. during an observation of the dining room two surveyors observed and confirmed with the maintenance supervisor that the ice machine did not have the 1-inch air gap as required.	F 812	See Attached.	

Borderview Rehab and Living Center
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Annual Survey
Plan of Correction June 10, 2025

Please note, the filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The facility is filing this plan of correction in accordance with applicable laws.

F 584~ Safe/Clean/Comfortable/Homelike Environment CFR(s):483.10(i)(1)-(7)

Corrective Action:

Wheelchair

- Wheelchair arms and leg rest for "Resident #3 were replaced.
- An audit will be performed on residents' wheelchairs to ensure no others are damaged, and addressed as needed.
- A quality check tool, was created to track and document findings during quality checks. Maintenance, DNS or designee will perform audits routinely to monitor the condition of durable equipment.
- Education provided to maintenance staff and nursing staff on monitoring condition of equipment and furniture.
- Results of quality checks will be reported to the facility's Quality Assurance Committee for 6 months, as indicated.

Room Cleanliness

- Rounding and cleaning of resident #2's pole, used to hold his feeding nutrition bag and space surrounding the area, was added to housekeeping schedule to be completed routinely.
- Audit tool will be created. Housekeeping Supervisor along with Infection Preventionist will complete audits regularly.

O2 Concentrator

- An audit will be completed on O2 concentrators to ensure they are clean and free of dust and debris.
- A nursing measure treatment, will be added to EMR for residents who have an oxygen concentrator, to schedule routine cleaning of concentrators.
- Routine quality checks will be done to ensure O2 concentrator remain free of dust and debris.
- Education on importance to keep concentrators clean and how to clean concentrators will be provided to nursing staff.

Ice Maker

- Maintenance has added the inspection of the ice maker to their preventative maintenance schedule. Maintenance will clean/remove any build up as needed. Maintenance will clean the side vent and ensure the drip tray is free of paint chips or rust.
- A tracking /quality tool was created to document quality checks, findings and repairs or replacements. Housekeeping staff and Infection Preventionist will also monitor and report finding to maintenance.
- Education provided to maintenance, Infection Preventionist and housekeeping staff on importance of keeping ice maker clean and what risks of infection are associated with uncleaned/unsanitary ice maker.

Tables/counter top/sink

- Dietary staff will be provided with education on their job duties related to cleaning SNF/NF dining room/activity center after meals, specifically in the evenings.
- Guidance related to updated daily tasks of, cleaning sink area, ice machine, wall around the counter/sink, cabinets, and tables was provided to housekeeping staff.
- Audit tool will be created. Housekeeping Supervisor, Dietary Supervisor, along with Infection Preventionist will complete audits regularly and report to the Quality Assurance committee for the next two quarters.
-

Date of completion: June 25, 2025

F 677~ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)

Corrective Action:

Mouth Care

- Education provided to nursing staff on proper way to perform mouth care and frequency.
- DNS or designee will perform quality checks routinely to ensure proper mouth care is being completed.
- A quality check tool was created to track and document findings during quality checks. Finding results will be used to provide additional training and education as needed.
- Results of quality checks will be reported to the facility's Quality Assurance Committee for 6 months, as indicated.

Date of completion: June 25, 2025

F 812~ Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)

Corrective Action:

Air Gap

- The "air gap" separation on the ice machine drain line was fixed immediately upon discovery.
- Education will be provided to maintenance staff related to "air gaps".
- Maintenance Director or maintenance assistant will quality check drain pipes regularly to ensure proper air gap. Air gaps will be corrected should it not have the correct air gap.
- Residents were not affected by this deficient practice but could have been.

Steam Table

- Dietary staff will be educated on appropriate food temperatures, proper times and procedures to take food temperature.
- Dietary Supervisor or designee will regularly attend meal services, to quality check and ensure temperatures are acceptable prior to serving.
- Education will be provided to dietary staff on proper food temperatures and how to take food temperatures.
- Concerns will be brought to the Facility's Quarterly Assurance committee meetings as needed.

Date of completion: June 25, 2025

Darlene Lawder
Assistant Administrator
6/11/25

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

Maine Department of Health and Human Services
Licensing and Certification
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel.: (207) 287-9300; Toll Free: (800) 791-4080
TTY: Dial 711 (Maine Relay); Fax: (207) 287-5815

June 2, 2025

Darlene Lavoie, Administrator
Borderview Rehab & Living Ctr
208 State Street
Van Buren, ME 04785
Sent via email only, to: DLavoie@ncaltc.com; TLDionne@ncahcf.com

RE: Notice of Survey Results and Enforcement

Dear Ms. Lavoie:

On May 14, 2025, the Division of Licensing and Certification ("DLC") conducted a survey at Borderview Rehab & Living Ctr to determine the facility's compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that Borderview Rehab & Living Ctr was **not** in substantial compliance with the participation requirements. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations ("42 CFR").

Plan of Correction ("POC")
A POC for these deficiencies must be submitted **ten (10) calendar days** after today's date. Failure to submit an acceptable POC within ten (10) calendar days from today's date may result in the imposition of remedies determined by CMS.

To be acceptable, a POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected. Corrections must be made no later than June 28, 2025

You may provide your POC for the listed deficiencies under the column titled, "Provider's Plan of Correction" or you may submit the POC as a separate document. **For either format submitted, the first page of the CMS-2567 must be signed and dated by an official facility representative and must be submitted.** Please send your POC by email to Celine Donohue, R.N. at Celine.Donohue @Maine.gov and Cherrie Manzo at Cherrie.Manzo@Maine.gov.

The Form CMS-2567 and approved plans of correction are releasable to the public in accordance with the provisions of Section 1819(g)(5) and 1919(g)(5) of the Act and 42 CFR §488.325. As such, the POC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names.

The POC will serve as the facility's allegation of compliance. The State Agency will conduct a revisit survey to verify compliance.

Other Remedies:

A. Denial of Payment for New Admissions ("DPNA")

Per 42 CFR §488.417(b)(1), the CMS and/or the State Medicaid Agency **must** deny payments for new admissions if the facility is **not** in substantial compliance three (3) months after the last day of the survey identifying the noncompliance. This three (3) month date is August 14, 2025.

B. Termination of Provider Agreement:

Per 42 CFR §488.456(b)(i), the CMS and/or the State Medicaid Agency will terminate the facility's provider agreement if the facility does not achieve substantial compliance within six (6) months after the last day fo the survey identifying noncompliance. This six (6) month date is November 14, 2025.

Please note that this letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. If it is determined that termination or any other remedy is warranted, you will be provided with a separate formal notification of that determination.

Nurse Aide Training and Competency Evaluation Program ("NATCEP") Prohibition

A prohibition against the provision of a Nurse Aide Training and Competency Evaluation Program ("NATCEP") either by your facility or by another entity on the premises of your facility will be imposed if one or more of the following situations occurs. Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2) (B), prohibits approval of nurse aide training and competency evaluation programs and/or nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has

- operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty (CMP) of not less than $13,343.00;
- been subject to a denial of payment, the appointment of a temporary manager or termination;

or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If the prohibition is imposed, any programs/sessions that are currently running, will be allowed to run to completion. Once completed, no new programs will be allowed until the prohibition has finished.

The two-year prohibition will be effective, as applicable, with: (1) the expiration of the 60-day period for filing a written request for a hearing; or, (2) the receipt of your written waiver of the right to a hearing within the specified time period; or (3) the date of the final administrative decision upholding the CMP in the amount of $13,343.00 or more. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies have been

rescinded. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

Please note that this letter does not constitute formal notice of imposition of NATCEP prohibition. If it is determined that the NATCEP prohibition is imposed, you will be provided with a separate formal notification of that determination.

Informal Dispute Resolution ("IDR")

In accordance with 42 CFR §488.331, the facility has one (1) opportunity, which is through the IDR process, to dispute the deficiencies cited at the survey. To request an IDR, send the following, via email, to Celine Donohue, R.N. at Celine.Donohue@Maine.gov and to Cherrie Manzo at Cherrie.Manzo@Maine.gov within ten (10) days of receipt of the CMS-2567:

- Your written request for an IDR;
- The specific deficiencies being disputed; and
- An explanation of why you are disputing those deficiencies.

An IDR may **not** be used to challenge the:

- Scope and severity assessment of deficiencies (except for deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed; or an
- Alleged inadequacy or inaccuracy of the IDR process.

Additionally, an IDR may **not** be used to challenge any aspect of the survey process, including but not limited to:

- Any alleged failure of a surveyor team to comply with a requirement of the survey process; or
- Any alleged inconsistency of the surveyor in citing deficiencies among facilities.

Contact Information:

If you have any questions concerning the information contained in this letter, please contact me via email at the email address above.

Sincerely,

Celine Donohue

Celine Donohue, R.N.
Long-Term Care Supervisor
Division of Licensing and Certification

Attachment: Form CMS-2567

CD/cm

Sent, via email only, to:
Long-Term Care Ombudsman Program
Lynn Q. Hadyniak, J.D. - Assistant Director, Medical Facilities Unit

Event ID: 3UH511