

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Helen Porter Healthcare & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Porter Drive Middlebury, VT 05753	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure that 2 of 3 sampled residents (Resident #1 and Resident #2) were free from mental abuse by staff by failing to protect Resident #1 from verbal abuse from staff in the form of mocking, insulting, and ridiculing, and failing to protect Resident #2 from being deprived of necessary services necessary to avoid emotional distress. Findings include: 1. Per record review, Resident #1 had an MDS (Minimum Data Set, a resident assessment tool) dated 1/8/26, showing a BIMS (Brief Interview for Mental Status) score of 9, indicating moderate cognitive impairment (the ability to perceive, learn, remember, reason, and problem-solve). Per review of a facility investigative summary report dated 1/27/26, submitted to the State Agency on 1/27/26, Resident #1 was receiving care from LNA #1 (Licensed Nursing Assistant) and LNA #2 on 1/23/26. Per LNA #1 and LNA #2, Resident #1 had been incontinent of his/her bowels. During care, Resident #1 was noted to be yelling and could be heard outside of his/her room. LNA #3 and LNA #4 both responded to check on Resident #1. Per the facility investigative summary report, LNA #3 stated, that when she popped into [Resident #1]'s room to check on [him/her], [LNA #1 and LNA #2] were laughing, and they said that [Resident #1] screams like a little girl. LNA #4 said in her statement dated 1/27/26 attached to the facility investigation that when she went into Resident #1's room, LNA #1 and LNA #2 were laughing and said that Resident #1 screams like a little girl. They said to LNA #3 when they left the room that Resident #1 is funny and screams like a little girl. Per review of the statement given by LNA #4 during the facility investigation, she stated that she could hear Resident #1 screaming from down the hall during care by LNA #1 and LNA #2. When she entered the room, LNA #1 was by the wall, LNA #2 was on the other side of the bed, and Resident #1 was yelling and kicking. LNA #1 and LNA #2 stated that the resident was mad that they had to use the patient lift. Then they mocked [him/her] hehehehehe and laughing. LNA #4 further stated that LNA #1 and LNA #2 were mimicking [Resident #1] kicking and screaming and something about [Resident #1] being a baby. Per interview with LNA #4 on 7/8/26 at 11:00 AM, she confirmed her prior statement from the facility investigation and stated it was not okay to make fun of a resident. Per review of the statement given by Resident #1 as part of the facility investigation on 1/26/26, s/he recalled the incident three days after it occurred and stated s/he recalled people laughing and mocking him/her. Resident #1 stated s/he recalled hearing his/her name and then laughing and mocking him/her from the hallway and was afraid they were going to hurt me after they were done laughing. Per review of the facility policy titled Prevention of Abuse, not dated, Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. It also states Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written or gestured communication or sounds to residents within hearing distance, regardless of age, ability to comprehend or disability. (continued on next page)		

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to protect Resident #1 from verbal abuse from staff in the form of mocking, insulting, and ridiculing. 2. Per record review, Resident #2 has an MDS (Minimum Data Set, a resident assessment tool) dated 2/11/26, showing a BIMS (Brief Interview for Mental Status) score of 15, indicating intact cognition (the ability to perceive, learn, remember, reason, and problem-solve). Per review of a facility investigative summary dated 2/4/26, submitted to the State Agency on 2/4/26, it stated the following, On February 4, 2026, at approximately 7:45 AM, [LNA (License Nursing Assistant) #6] found [Resident #2] heavily soiled with urine during morning care. The brief, pad, chuck, sheet, and mattress were all saturated, and [Resident #2] had placed tissues between [her/his] legs in an attempt to manage the urine. [Resident #2] told LNA #6 that [s/he] had rung for assistance but an LNA allegedly told [him/her], I just toileted you 10 minutes ago. I'm not toileting you again, you have a diaper on. When asked about the prior evening, [Resident #2] stated that staff member [LNA #5] dismissed [her/his] request to use the bathroom, turned off [her/his] call light, left the room, and did not return-resulting in [Resident #2] urinating in [her/his] underwear. Per the statement of Resident #2 on 2/4/26, s/he stated that when LNA #5 answered her/his call bell, she came in and I told her that I had to go to the bathroom and she said that I went 20 minutes ago and didn't have to go again. She turned off the light and left the room and never came back. When asked if s/he used the call light again, Resident #2 stated, I just peed in my underwear. Per interview with LNA #6 on 7/8/26 at 12:10 pm, she stated she believed Resident #1 was telling the truth when Resident #1 told her what happened. The evidence in the room supported Resident #1, urine-soaked clothing, linens and the smell of urine. The facility investigative summary report sent on 2/5/26 stated that Resident #3, the roommate of Resident #2, corroborated the events including the reference to diapers. Per review of the facility investigation summary report dated 2/5/26, Resident #3 has a BIMS of 15, indicating fully intact cognition. Resident #3's statement on 2/4/26 said that LNA #5 responded to his/her roommate's call light and refused to take Resident #2 to the bathroom. S/he also stated that a few times during the night, LNA #5 indicated that Resident #1 needed to wear diapers. Per interview with Resident #3 on 7/8/26 at 10:50 AM, s/he confirmed his/her statement s/he gave at the time of the incident stating it was the truth. Per interview with a family member of Resident #1 (also a facility social worker) on 7/8/26 at 11:25 AM, s/he stated that s/he believed the incident did occur. The family member stated in regard to Resident #3, that s/he is cognitively intact and pays great attention to what Resident #2 is doing, intrusively so. Per interview with the Administrator on 7/8/26 at 11:40 AM, Resident #3 is intrusive, very interested in what is happening with Resident #2. The Administrator stated that Resident #2 was truthful in that her/his perception of the incident with LNA #5 was truth to her/him The facility failed to protect Resident #2 from being deprived of a necessary service resulting in emotional distress and impacting Resident #2's dignity. Based on corrective actions completed prior to the onsite survey, this citation is designated as past non-compliance. The following actions were completed by the facility: Following an investigation, LNA #5 no longer works at the facility. Alert and oriented residents on the affected units were interviewed after the incident (s) and there were no additional findings. They were interviewed weekly x4 and monthly x3 to assure compliance. Facility staff have been re-educated on residents' rights, and the facility abuse policy and procedure, including timely reporting of incidents of alleged abuse. Education on residents' rights was added to the facility's weekly newsletter, dated 1/30.26. Weekly audits of timely reporting of allegations of abuse were implemented weekly x4 and then monthly x3. The facility's corrective actions were completed on 2/13/26.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an incident of alleged abuse for 1 of 3 sampled residents, Resident #1. Findings include: A facility investigative summary report dated 1/26/26 revealed an allegation of staff to resident abuse. The incident occurred on 1/23/26 at 7:00 PM and was not reported to Survey & Certification until 1/26/26 at 3:31 PM, exceeding the required 2-hour reporting window. Per interview with the Administrator on 7/8/26 at 11:40 AM, she confirmed that the incident was reported late, it was not reported to her at the time and that she had learned about it when reading an internal incident report. Based on corrective actions completed prior to the onsite survey, this citation is designated as past non-compliance. The following actions were completed by the facility: Alert and oriented residents on the affected units were interviewed after the incident (s) and there were no additional findings. They were interviewed weekly x4 and monthly x3 to assure compliance. Facility staff have been re-educated on residents' rights, and the facility abuse policy and procedure, including timely reporting of incidents of alleged abuse. Weekly audits of timely reporting of allegations of abuse were implemented weekly x4 and then monthly x3. The facility's corrective actions were completed on 2/13/26.		