

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 07/20/2026
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 - Few Note: The nursing home is disputing this citation.	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 residents were free from abuse for two out of six residents sampled (Resident #1 and Resident #2). This is a repeat deficiency for this facility, with the violation cited during a previous complaint survey dated 7/8/26. Findings include: Per record review Resident #1 has a BIMS [Brief Interview of Mental Status] of 3 as of 3/11/26, indicating s/he has severe cognitive impairment. Resident #1 has diagnoses of vascular dementia, adjustment disorder with anxious mood, Type II Diabetes mellitus, generalized weakness, and expressive aphasia (A brain-related language disorder with difficulty speaking or writing). Per record review, Resident #2 has a BIMS score of 1 as of 6/12/26, indicating severe cognitive impairment. Resident #2 has diagnoses of severe late onset Alzheimer's dementia with mood disturbance, anxiety, hypertension (high blood pressure), and insomnia. Per review of the facility's internal investigation documentation, Resident #1 and Resident #2 were involved in an altercation on 2/15/26. Per review of a witness statement from LNA#1 it states, At 9:10 PM [on 2/15/26] I was sitting at the nurse's station charting and watching [another resident]. I overheard screaming and yelling from [Resident #1] and [Resident #2] coming from the living area. I came out of the nursing station and observed both [Resident #1] and [Resident #2] punching and slapping each other around the arms. I removed [Resident #2] from the area and immediately told [Licensed Nurse #1] what happened. She told me to put [Resident #2] to bed. I told her [Resident #2] does not go to bed until 12:00 AM. I told her both residents names and she looked at me and said nothing. I told her she has to make her a nursing incident report. She ignored me. I kept [Resident #2] with me, until I had to do rounds. [Licensed Nurse #2] came back from break and I told him what happened. He immediately took charge and told both nurses how to document this situation. Upon further review of the facility's internal investigation it states, [LPN#1] assessed [Resident #1] and [Resident #2], no injuries and no recall of the incident. [LPN#1] completed skin checks again today (2/16) and noted no new marks, both residents are at baseline. Per review of the facility's Prevention of Abuse policy [no revision date] it states, [Facility] has the responsibility to ensure that each resident has the right to be free from abuse. no abuse or harm of any type will be tolerated. An interview was conducted with the Administrator on 7/20/26 at 10:39 AM. She confirmed the incident of resident-to-resident abuse occurred.		

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to ensure that two of six sampled residents (Resident #1 and Resident #2) care plans were revised following an incident of resident-to-resident abuse. Findings include: Per review of the facility's internal investigation documentation, Resident #1 and Resident #2 were involved in an altercation on 2/15/26. Per review of a witness statement from LNA#1 it states, At 9:10 PM [on 2/15/26] I was sitting at the nurses station charting in watching resident I overheard screaming and yelling from resident number one and resident #2 coming from the living area I came out of the nursing station and observed both [Resident #1] and [Resident #2] punching and slapping each other around the arms. I removed [Resident #2] from the area and immediately told [Licensed Nurse #1] what happened. She told me to put [Resident #2] to bed. I told her [Resident #2] does not go to bed until 12:00 AM. I told her both residents names and she looked at me and said nothing. I told her she has to make her a nursing incident report. She ignored me. I kept [Resident #2] with me, until I had to do rounds. [Licensed Nurse #2] came back from break and I told him what happened. He immediately took charge and told both nurses how to document this situation. Per record review Resident #1 has a BIMS [Brief Interview of Mental Status] of 3 as of 3/11/26, indicating s/he has severe cognitive impairment. Resident #1 has diagnoses of vascular dementia, adjustment disorder with anxious mood, Type II Diabetes mellitus, generalized weakness, and expressive aphasia (A brain-related language disorder with difficulty speaking or writing). Resident #1's care plan dated of 8/20/24 states, [Resident #1] will not be physically or verbally aggressive with others. There are interventions such as Provide frequent checks on [Resident #1], watch for signs of increasing anxiety, watch for signs of increasing agitation, approach calmly, remove from setting, administer prescribed medications, observe for side effects such as lethargy, loss of appetite, establish routines, inform social worker. There is a care plan goal documented on 4/11/25 stating [Resident #1] will not harm self or others. Per record review, Resident #2 has a BIMS score of 1 as of 6/12/26, indicating severe cognitive impairment. Resident #2 has diagnoses of severe late onset Alzheimer's dementia with mood disturbance, anxiety, hypertension (high blood pressure), and insomnia. Per review of Resident #2's care plan documented on 1/14/26 it states, Risk for physical harm and psychosocial distress related to resident-resident altercation 1/14/26 (another resident grabbed this resident). Goal: Resident will remain free from physical harm and will feel safe. There were no additional interventions added to the care plans for Resident #1 and Resident #2 after the date of the resident-to-resident incident on 2/15/26. An interview was conducted with the Administrator on 7/20/26 at 12:17 PM. The Administrator confirmed that the care plans for Resident #1 and Resident #2 did not have any additional documentation of interventions after the incident that occurred on 2/15/26. Per review of the facility's Care Planning policy [date effective 10/1/25] it states, 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to ensure two of three sampled residents (Resident #3 and Resident #4) had narcotics appropriately documented and signed in from the pharmacy. Findings include: 1. Per record review, Resident #3 has an order for Oxycodone [a medication used to treat pain] IR [Immediate Release] 5 mg [milligram] tab [tablet]: Take one tab po [by mouth] q4h p [every four hours] prn [as needed] for pain. Per review of the facility's internal investigation report dated 6/6/26 it states, On 6/6/26, I received a call to inform me [RN#1] reported to [RN#2] the narcotic count was off by one in the East Cart during count. The narcotic log indicated that there should have been 37 tablets but there only 36. The pill was unable to be located. [RN#1] further state that she believed that she had accepted four cards of narcotics from the pharmacy on a previous shift but had not signed them in and that she could not find the cards. [RN#2] (on call manager) verified the count was 36 and not 37 and searched the cart for the missing pill which was unable to be found. She went through the entire cart and located the four cards of narcotics. These were verified against the manifest and found to be accurate. They were then logged into the narcotic record and signed off with another nurse. Per review of the facility's five-day investigation it states, No evidence of medication diversion was identified during the investigation. The discrepancies were determined to be the result of documentation errors and medication removal from an incorrect resident-specific narcotic sleeve. Per review of the facility's Medication Ordering and Receiving From Pharmacy policy [no revision date] it states, K. Only licensed personnel may receive controlled substances from the pharmacy driver/courier. Procedures for receiving controlled substances include: 1) A nurse signs for the medications, including the controlled substances, on the pharmacy delivery ticket and inspects the medications. 2) A nurse reconciles controlled substance orders and refill requests against what has been received from the pharmacy. 3) A nurse notifies the pharmacist if controlled substance orders or doses are missing or incorrect. 4) The receiving nurse transfers medication and accompanying inventory sheets to an authorized nurse on the unit (if different than the nurse who received the medication). 5) Two nurses witnessed placement of the controlled substances in the secured compartment of the medication cart. 6) controlled substance inventory sheets are completed, if necessary, and filed appropriately. A hard bound log book is utilized to track the controlled substance from delivery to disposition. An interview was conducted with the Administrator on 7/20/26 at 12:03 PM. The administrator confirmed they could not find the oxycodone pill and RN #1 did not follow the appropriate protocol for signing in narcotics. A telephone interview was conducted with RN#2 on 7/20/26 at 12:23 PM. RN#2 states RN#1 and RN#2 were initially unable to find the tablet of oxycodone, but it was subsequently found that Monday morning (6/8/26). RN#2 confirmed RN#1 took the four cards of narcotics and threw them into cart and planned on signing them later in her shift. RN#2 confirmed RN#1 then forgot where she put the cards of narcotics. RN#2 confirmed the four cards were found in the medication cart. RN#1 verified two nurses are supposed to do the narcotic count prior to the courier leaving and did not do this and should have. 2. Per record review of the narcotic log located on the medication cart in the Post-Acute Care Unit, Resident #4 had an order for Oxycodone 5 mg [milligram] tab: Take one half tab po [by mouth] q6h [every six hours] prn [as needed] pain. On 7/14/26 an additional 20 oxycodone were added to the narcotic count. The additional 20 pills were only signed out by one Licensed Nurse. An interview was conducted with RN#3 on 7/20/26 at 12:45 PM. She confirmed the additional 20 oxycodone 5 mg tablets added to the narcotic log for Resident #4 was only signed by nurse. When asked if two licensed nurses needed to sign off narcotics added to a log she stated, I don't know, I've been told different things.		