VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

September 25, 2025

Ms. Amy Walker, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753

Provider ID #: 475017

Dear Ms. Walker:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **August 27, 2025.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helen Porter Healthcare & Rehab	30 Porter Drive , Middlebury, Vermont, 05753

(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
E0000	Initial Comments The Division of Licensing and Protection conducted an annual emergency preparedness survey on 8/27/25. The facility was found in substantial compliance with emergency preparedness regulations.	E0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited in the CMS-2567 Form. Submission of this Plan of Correction is made solely to meet the requirements established under state and federal law and does not constitute an admission that a deficiency exists or that any deficiency was cited correctly.	
F0000	INITIAL COMMENTS An unannounced, on-site re-certification survey was conducted by the Division of Licensing and Protection on 8/25/25 through 8/27/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Three facility reported incidents were also investigated (#149512, #2567285, and #2576978). The following regulatory violations were identified:	F0000		
F0742 SS = D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide treatment and services for 1 applicable resident (Resident #79) diagnosed with post-traumatic stress disorder (PTSD). Findings include: Per record review, Resident #79 has a diagnosis of post-traumatic-stress disorder (PTSD) and, as a result, suffers from nightmares and sleep disturbances. Per review of Resident #79's Plan of care meeting notes dated 7/7/25, it mentions how "Patient said [he/she] continues to have nightmares and wants to follow-up	F0742	F742 s/s D Treatment/Srvcs mental/Psychosocial Concerns 1.A contract is being worked on with the Counselling Service of Addison County, Inc (CSAC) for talk therapy. Resident #79 will be referred to CSAC for talk therapy once the contract is in place. 2.Residents with a history of trauma and/or PTSD have been identified and referrals to CSAC will be made for those that want it. 3. Education to be completed with social services and nurse leadership to ensure that patients/residents with a history of trauma and/or PTSD have been offered behavioral health services as noted in the Behavioral Health Care & Services Policy for Helen Porter. 4. Audits to ensure current residents/patients and new admissions (patients/ residents) with a history of trauma and/ or PTSD have been offered Behavioral Health Services will be done weekly for 4 weeks, monthly for 3 months. Any concerns will be brought to QAPI and addressed immediately. Date of Compliance: 10/10/2025 **Tag F 742 POC accepted on 9/25/25 by S. Davies/S. Stem**	

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 reverse for further 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 NHA	(X6) DATE 9/22/25

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F0742 SS = D	Continued from page 1 with provider. Nursing agreed to direct that concern to provider." Per interview with Resident #79 on 8/25/25 at 12:39 PM, s/he reported that nobody here is following up with him/her for psychological services. S/he reports that they have asked many times to have a psychologist to support them with their PTSD. The Resident reports s/he asks every care meeting to get a psychologist or someone from psych services to talk to, but they have not initiated it. Resident #79 reports s/he has tried to keep themselves busy, but s/he really wants to get psychological services and care to help support them with this diagnosis that resulted from a traumatic accident. Per observation of Resident #79 during the interview on 8/25/25 at 12:39 PM, Resident #79 is tearing up while talking about how they have PTSD and have been unable to get psychological services to help support them in coping with how PTSD has impacted them. Per interview with the Unit Manager Nurse (UNM) on 8/27/25 at 12:56 PM, s/he reported that Resident #79 hasn't seen anyone for psychological services and that nobody on the unit is receiving services. The UNM reported that there are no psychological providers, including telehealth, and that the Administrator has been working on it since she started at the facility in November. Per interview with the Administrator on 8/27/25 at 1:24 PM, s/he revealed that the residents have been without psychological services since at least November of 2024. Per interview with the Administrator and Director of Nursing on 8/27/25 at 2:20 PM, they reported that they use social services, palliative care services, a Chaplain, and a psychiatric provider at Porter Medical Center who doesn't see or treat patients but offer advice to the facility's provider to help address any psychological needs. The Administrator also reported that s/he has informed the Vice President (VP) that residents are unable to receive services and of the regulations that require this. The Administrator shared a facility evaluation binder addressing the lack of behavioral health services. Per interview with the Social Worker on 8/27/25 at 2:35 PM, s/he reported that s/he doesn't ask residents if they want psychological services because they are unable to provide them, but s/he keeps a list of those who would benefit from services. S/he stated that it has been at least three years since psychological services have been provided and that it's due to their internet security department being unable to give	F0742		

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F0742 SS = D	Continued from page 2 clearance to outside providers. The social worker also stated that they have residents who need psychological services and "deserve it" and that while the social workers can reflect and listen, they really need a licensed psychologist. Additionally, s/he stated the physician there often recommends people for psychological services, but then they can't provide the services. Per review of Resident #79's social services notes, the most recent visit was on 5/20/25, despite this being used as a method in place of psychological treatment and services. Per interview with the Administrator on 8/27/25 at 4:40 PM, s/he confirmed that the last documented time Resident #79 saw social services was on 5/20/25. Per review of the facility policy titled "Behavioral Health Care & Services" dated 4/8/2025, it states the purpose is "To provide the necessary behavioral health care and services to attain or maintain the highest practical, physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care... Each patient/resident (hereinafter "patient") must receive, and Helen Porter Health & Rehab Center (HPHRC) must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a patient's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders...1. Patients will be provided the necessary behavioral health care and services to include: 1.1 Ensuring that the necessary care and services are person-centered and reflect the patient's goals for care, while maximizing the patient's dignity, autonomy, privacy, socialization, independence, choice, patient rights, and safety...".	F0742		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by:	F0759		

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F0759 SS = D	Continued from page 3 Based on observation, interview, and record review, the facility failed to ensure medication error rates were not 5% or greater. The total error rate for all observations was calculated at 6.45%. There were 31 medication administration opportunities observed, resulting in 2 errors for 1 of 5 sampled residents (Resident #71) due to not following administration recommendations and not accurately documenting medication administration. Findings include: Per observation on 8/27/25 at 8:34 AM, a Licensed Practical Nurse (LPN) began the process of administering medications to Resident #71. Five medications were crushed together, poured into a medicine cup with yogurt, and Polyethylene glycol 3350 (MiraLAX, a drug prescribed for constipation) was mixed into a half-full 9-oz cup of water. The mixed crushed medications were administered to the resident, and the resident marginally consumed the Polyethylene glycol 3350 and water mixture. The LPN disposed of the remainder of the Polyethylene glycol 3350 and water mixture. Per interview on 8/27/25 at 8:41 AM, the LPN confirmed Polyethylene glycol 3350 was documented as administered, which should have been documented as partially administered. Per review of Resident #71's physician orders, levothyroxine 75mcg (a medication used to treat an underactive thyroid, hypothyroidism) states "give 30-60 minutes before breakfast, separate from food and other medications. Separate 4 hours from antacids, iron, or calcium products." Per interview on 8/27/25 at 9:00 AM, the LPN confirmed the medication had been mixed with the resident's other pill medications and added to yogurt. Per interview on 8/27/25 at 9:21 AM, the Unit Manager confirmed that mixing levothyroxine 75mcg with other medications and in yogurt constitutes a medication error. Facility policy "Medication Administration," effective date 4/9/2025, reads, "It is the responsibility of the person administering the medication to be knowledgeable about the medication, including its use, side effects, toxicity, and interactions", and "Check the electronic medication administration record/medication	F0759	F759 s/s D Free of Medication Error Rates 5% or More 1. Resident 71 now receives medications as ordered by the provider. 2. All patients/residents at Helen Porter have the potential to be affected by this deficient practice. An audit is being completed by observation, interview and/or chart review for medication administration to ensure proper administration practices are followed for all residents/patients and that the medication administration error rate is below 5%. 3. Education is being done with all direct care nursing staff per Helen Porter's "Medication Administration" policy dated 04/09/2025 including its use, side effects, toxicity, and interactions as well as checking the electronic medication/ administration record/order/protocol for drug to be administered. 4. Audits will be conducted 3x a week for 2 weeks, weekly f or 6 weeks, then monthly for 2 months ensure that all patients/ residents are receiving medications as ordered by the provider. Any concerns will be brought to QAPI and addressed immediately. Date of Compliance: 10/10/2025 **Tag F 759 POC accepted on 9/25/25 by S. Davies/S. Stem**	

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F0759 SS = D	Continued from page 4 order/protocol for drug to be administered."	F0759		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to store medications and biologicals within expiration dates, and safely for 1 of 6 residents (resident #17). Per observation and interview on 8/26/25 at 11:28 AM of the Medication Storage room on Memory Care Unit, with the Unit Manager, the following items were found and confirmed expired: 28 Vacutainer blood collection tubes (a sterile glass or plastic test tube with a colored rubber stopper facilitating the drawing of blood) expired on 11/01/2023 15 ESwab collection and transport sampling tubes (is used to collect clinical specimens containing aerobic (are bacteria that can grow and live when oxygen is	F0761	F761 s/s D Label/Store Drugs and Biologicals 1. All expired medications and medical supplies were discarded. Resident 17 now receives her medications according to the Helen Porter policy "Medication Administration". 2. All patients/residents at Helen Porter could be affected by this deficient practice. 3. Education has been completed with all direct care nursing staff regarding labeling and disposal of expired medications and medical supplies. Education has been completed with all direct care nurses per Helen Porter's "Medication Administration Policy". 4. Audits will be conducted 3x a week for 2 weeks, weekly for 6 weeks, and monthly for 2 months to ensure that all patients/residents are receiving medications as ordered by the provider. Any concerns will be brought to QAPI and addressed immediately. Date of Compliance: 10/10/2025 **Tag F 761 POC accepted on 9/25/25 by S. Davies/S. Stem**	

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F0761 SS = D	Continued from page 5 present), anaerobic (are germs that can survive and grow where there is no oxygen) and fastidious bacteria (are microorganisms that are difficult to cultivate in the lab due to their complex or limited nutritional and/or environmental requirements) from the collection site, and transport them to the testing laboratory) expired on 8/24/2025 2 Micro-Kill Bleach Germicidal Bleach Wipes (Premoistened wipes with solution equivalent to 1:10 dilution of 6.5% bleach and is effective against 62 microorganisms including Acinetobacter baumannii-MDR, Klebsiella pneumoniae, E. coli, MRSA, VRE, VRSA, and VISA) expired on 12/22/2024 and 1/23/2025 Per interview on 8/26/25 at 11:28 AM, the Unit Manager confirmed items are expired. References: https://medlineplus.gov/ency/article/003437.htm https://medlineplus.gov/ency/article/002230.htm https://www.biologyonline.com/dictionary/fastidious Per review of the facility's "Medication Administration" policy [last date effective 4/9/25] states, "9. Assist the patient to a comfortable position. If oral medication is being administered, the clinician administering the medication will observe the patient taking the medication. Mouth checks may also be warranted for some medications or patients." Per review of Resident #17's EMR [Electronic Medical Record] Resident #17 has a BIMS [Brief Interview of Mental Status] score is 11, indicating there is mild cognitive impairment. Resident #17 had diagnoses of DM Type II [Diabetes Mellitus Type II], COPD [Chronic Obstructive Pulmonary Disease], edema, chronic pain syndrome, and a closed compression fracture of L1 lumbar vertebrae. Per observation on 8/27/25 at 1:00 PM 2 white tablets were found to be left at Resident # 17's bedside. An interview was conducted with RN #1 at approximately 1:01 PM. She confirmed the two tablets left at the bedside were Torsemide [a medication known as a loop diuretic that is used to treat fluid retention] 20 mg [milligram] tablets.	F0761		

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F0761 SS = D	Continued from page 6 Per record review, Resident #17 takes Torsemide 20 mg tablets: Take two tablets po [by mouth] BID [twice a day] and 3 tabs po QHS [Every Night]. Per interview with RN#1 on 8/27/25 at approximately 1:02 PM she confirmed that the medication was left at the bedside and should not have been, stating, "I walked out of the room and thought [s/he] took them."	F0761		
F0812 SS = F	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, interview, and record review the facility failed to store food in accordance with professional standards for food service safety. Findings include: Per review of the facility's "Food Safety Systems: Surveillance, Prevention, and Control" policy [last revised 7/2024] states, "b. All opened or prepared foods will be stored in an approved container (with the appropriate cover), labeled with a description of the food item and the date prepared or opened...C. Labeling...b. TCS [Temperature Controlled for Safety]	F0812	F812 s/s F Food procurement, Store/Prepare/ Serve-Sanitary 1.Center food is being stored in accordance with professional standards for food service safety. All expired food has been discarded, and all opened food is labeled. 2.All patients/residents at Helen Porter could be affected by this deficient practice. 3.Education has been completed with dietary staff on "Food Safety Systems: Surveillance, Prevention, and Control" Policy in regard to discarding expired food and dating newly opened items. 4.Audits will be done 3x/week for 2 weeks, weekly for 6 weeks and then monthly for 2 months to ensure that all opened food is labeled and all expired food is discarded. Any concerns will be brought to QAPI and addressed immediately. Date of Compliance: 10/10/2025 **Tag F 812 POC accepted on 9/25/25 by S. Davies/S. Stem**	

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F0812 SS = F	Continued from page 7 foods shall be labeled with common name of the food, date the food was made and use by date... TCS food is discarded if not used within 7 days..." Per observation of the kitchen freezer on 8/25/25 at 10:41 AM, there was a five-pound bag of diced strawberries that was opened and undated. There was a bag of cut chicken and a bag of frozen meatballs that were opened and not dated. Per interview with the Dietary Manager on 8/25/25 at approximately 10:43 AM it was confirmed that these items in the freezer were opened and not dated. Per observation of the dry storage room on 8/25/25 at 10:45 AM there were two cans of chickpeas with an expiration date of 7/2025. There was a bag of prunes dated 8/17/25. Per interview with the Dietary Manager on 8/25/25 at 10:45 AM it was confirmed that the cans of chickpeas were expired, and the bag of prunes was past its used by date. Per observation of the memory care unit refrigerator on 8/26/25 at approximately 10:30 AM, three 8-ounce carts of milk were found to have an expiration date of 8/23/25. There was a block of Cabot cheese that was open and had no date. Per interview with LNA [Licensed Nursing Assistant] on 8/26/25 at 10:42 she confirmed these items were expired as well as opened and not dated. Per observation of the kitchen on 8/27/25 at approximately 2:55 PM 16 cranberry sauce packets were found in the refrigerator to have a used date of 7/27/25. Per interview with the Dietary manager on 8/27/25 at approximately 2:56 PM she confirmed these items should have been discarded. Per observation of the kitchen freezer on 8/27/25 at approximately 2:56 PM, there was a package of chicken breast, a packet of chicken patties, and a package of chicken tenders that were opened and not dated. The Dietary Manager confirmed on 8/27/25 at 2:56 PM that these items were opened and not dated.	F0812		