



**AGENCY OF HUMAN SERVICES**

**DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING**

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line (888) 700-5330

To Report Adult Abuse: (800) 564-1612

March 15, 2019

Ms. Maryjane Nottonson, Administrator  
Helen Porter Healthcare & Rehab  
30 Porter Drive  
Middlebury, VT 05753-8422

Provider ID #: 475017

Dear Ms. Nottonson:

The Division of Licensing and Protection completed a survey at your facility on **March 13, 2019**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements.

Congratulations to you and your staff.

Please **sign the enclosed CMS 2567 and return** to this office by **March 25, 2019**.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief

Enclosure

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

PRINTED: 03/15/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/13/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HELEN PORTER HEALTHCARE &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>30 PORTER DRIVE MIDDLEBURY, VT 05753</b>
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(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
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E 000 Initial Comments

An unannounced, on-site emergency preparedness survey was conducted by the Division of Licensing and Protection between 3/11-13/2018. The facility was found to be in substantial compliance.

E 000

F 000 INITIAL COMMENTS

An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 3/11-13/2018. The facility was found to be in substantial compliance.

F 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.