STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005033	A. BUILDING: _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTH- PORTER	85 EAST US HWY 6 VALPARAISO, IN 46383

(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) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State licensure hospital complaint investigation. Complaint Number: IN00413273 - No deficiencies related to allegations are cited. Dates of Survey: 3/12/2025 to 3/13/2025 Facility Number: 005033 Northwest Health - Porter is in compliance with 410 IAC 15-1.5-2 Infection Control, 410 IAC 15-1.5-6 Nursing Service, and 410 IAC 15-1.5-10 Utlization Review & Discharge Planning, Hospital licensure rules, in regard to the investigation of complaint IN00413273. QA: 5/7/2025	S 000		