STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150035	A. BUILDING 00 B. WING	01/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
A 0000 Bldg. 00	This visit was for an Federal Complaint investigation Complaint Number: IN00451400 Deficiencies related to the allegations cited. (A0144, A385, A395) Survey Date: 01/22/2025, 01/23/2025, and 01/27/2025 Facility Number: 005033 QA: 1/29/2025	A 0000	Submission of this plan of correction is not an admission by the Hospital that the citations are true or that the Hospital violated the cited deficiencies or rules. Immediately upon receipt of the Survey Deficiency Statement, The hospital's Chief Executive Officer (CEO), Director of Quality, Chief Nursing Officer (CNO), Chief Financial Officer (CFO), Assistant Chief Executive Officer (ACEO), Chief Operation Officer (COO), Chief Medical Officer (CMO) to review the survey findings Date completed: 02/04/25 Responsible Person: CEO The CEO notified and shared findings from the survey with the Governing Board Chairperson. Date Completed: 2/4/25	
A 0144 Bldg. 00	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. Based on document and interview, the facility failed to ensure care in a safe setting in one instance for 1 of 10 patient (P1) medical records reviewed. Findings include: 1. Facility policy titled "Patient Rights Policy", revision date: 03/07/2022. Patient Rights: Personal	A 0144	#2- Action Taken: The educator provided the Behavioral Health training and education to 100% of staff working by 1/27/25. After that date anyone not trained must complete education upon return to work but prior to providing care. No staff member will start their shift before education has been completed.	01/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darnella Young	Director of Quality	02/18/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	privacy and safety. 2. Facility policy titled "Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting", revision date: 06/08/2022, indicated All adolescent and adult patients who present for care will be screened for suicide ideation and behavior using the Columbia Protocol (Columbia-Suicide Severity Rating Scale (C-SSRS). On page 6, Table 1: Patient Safety Measures and Interventions Based on Screening Responses, Level of Risk: High- Initiate continuous observation (1:1 or in dedicated, secured, ligature resistant area or room), - RN to notify MD and MD to order Mental Health Professional face-to-face consult before leaves the area/unit, - All staff to use communication/de-escalation techniques, - If family/significant other with patient: Nurse to provide "Support Person Education", RN to Re-assess suicidal risk and need for suicidal precautions if there is an observed or stated change in behavior. Registered Nurse observe patient every 15 minutes and utilize the Frequent Observation Flow Sheet. 3. MR indicated P1 was admitted to the facility on 01/10/2025 at 1532 hours for suicidal ideation. MR indicated Notice of "Patient Rights and Responsibilities", was signed by P1 on 01/10/2025 at 1650 hours which included but not limited to patient have the right to an environment that is safe, preserves dignity and contributes to a positive self -image. Columbia-Suicide Severity Rating Scale (C-SSRS) was completed on 01/10/2025 at 1705 hours on P1, indicated patient level of risk is high. MR lacked documentation of completed 15-minute checks and having a sitter at bedside while a patient at the facility. Nurse Note dated 01/11/2025 at 1618 hours written by N1		Training and Education: Education includes: Columbia Suicide- Just In Time Tool (JIT), Patient Sitter Education, Suicide Risk Assessment and Interventions Columbia Protocol in Non- Behavioral Health Setting Policy. Education will also be provided during annual education /competencies. All new hires will be educated as part of the nursing orientation. Auditing Monitoring: Nurse administration/ designee will complete audits on all patients that screen high risk according to the Suicide Risk Assessment and Interventions Columbia Protocol and require a sitter, until 4 consecutive months with a 100% compliance rate (Patient sitter, continuous observation with Q15 documentation according to policy, Columbia Suicide Severity Rating Scale (C- SSRS) completed per shift, safe room checks and Risk level appropriateness) implemented 1/13/25. Ongoing internal audits will be conducted monthly by the nursing administration Leader/designee. Results will be reported to leadership safety huddle daily. Monthly report to the Quality Improvement Council, Medical Executive Committee and Governing Board. Responsible: Chief Nursing Officer	

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	(Registered Nurse) indicated security guard and ER tech notified nurse that patient in room ED11 was blue. Patient found on the floor, not breathing, cool to the touch, and mottled, no pulse was detected, MD1 notified. P1 was pronounced expired at this time by MD1 (Emergency Room Medical Doctor) on 01/11/2025 at 1625 hours. 4. In interview on 01/23/2025 at approximately 1430 hours, with A1 (Chief Nursing Officer, CNO), confirmed the patient (P1) did not have a sitter at the bedside and 15 minute checks were not completed for P1. 5. In phone interview with N1 (Registered Nurse) on 01/27/2025 at 1030 hours verified that P1 did not have a sitter assigned on 01/11/2025 and should have.			
A 0385 Bldg. 00	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. Based on document review and interview, the registered nurse failed to ensure patient assessment and/or vital signs every 4 (four) hours, failed to provide a sitter, and failed to document 15-minute monitoring safety checks for 1 of 10 patient (P1) medical records reviewed. The cumulative effect of these systematic problems resulted in the facility's inability to provide nursing care in a safe manner.	A 0385	In response to the Condition level citation the Leadership team developed and implemented this plan of Correction including policy reviews, revisions to process training and education for staff, and incorporation of an on-going audit and monitoring of plan . - see POC within tag A 395 ="" p=""> ="" p="">	02/26/2025

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A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review and interview, nursing services failed to assess patient and/or vital signs every 4 (four) hours, failed to document 15-minute monitoring safety checks, and failed to provide a sitter at the bedside for 1 of 10 patient (P1) medical records reviewed. Findings include: 1. Facility policy titled "ED Assessment and Reassessment", revision date 09/24/2024. To provide guidelines for standardizing the frequency of assessing and reassessing of patients that present in the emergency department including patients triaged and in the ED waiting area. Vital signs will be recorded every four hours or at a minimum on admission and at time of discharge and as needed by the patients condition. 2. Facility policy titled "Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting", revision date: 06/08/2022, indicated All adolescent and adult patients who present for care will be screened for suicide ideation and behavior using the Columbia Protocol (Columbia-Suicide Severity Rating Scale (C-SSRS). On page 6, Table 1: Patient Safety Measures and Interventions Based on Screening Responses, Level of Risk: High- Initiate continuous observation (1:1 or in dedicated, secured, ligature resistant area or room), - RN to notify MD and MD to order Mental Health Professional face-to-face consult before leaves the area/unit, - All staff to use communication/de-escalation techniques, - If family/significant other with patient: Nurse to	A 0395	#1 Action Taken: The ED Assessment and Reassessment policy was reviewed and no changes were required. Documentation flow was reviewed in the EMR and no changes were required. It was determined that it was non-compliance with the policy and education was provided to all staff members. Future follow up will be progressive discipline. Auditing and Monitoring: ED Assessment and Reassessment audits will be completed. A minimum of 50 ED patients per month will be audited from ESI 2 and 3 acuity ratings until there is 100% compliance for 4 consecutive months. Thereafter, ongoing internal audits will be conducted by the ED Department Leader/designee. All results will be reported to the leader safety huddle daily. The results will be reported to the Quality Improvement Council, Medical Executive Committee and Governing Board monthly. Responsible: Chief Nursing Officer #2- Actions Taken: The educator provided the Behavioral Health training and	02/26/2025

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	provide "Support Person Education", RN to Re-assess suicidal risk and need for suicidal precautions if there is an observed or stated change in behavior. Registered Nurse observe patient every 15 minutes and utilize the Frequent Observation Flow Sheet. 3. Review of P1 medical record indicated: a. Patient was admitted to the facility on 01/10/2025 for suicidal ideation. Columbia-Suicide Severity Rating Scale (C-SSRS) was completed on P1 indicated patient to be at a high risk for suicide. MR lacked documentation of completed 15-minute checks and lacked documentation of sitter at bedside while a patient at facility. b. Initial Medical Screen dated 01/10/2025 at 1620 hours indicated P1 was assessed by the triage nurse vital signs: pulse 84 bpm (beats per minute) (normal range 60-100 bpm), respiratory rate 16 brpm (breaths per minute) (normal range 10-21 brpm), blood pressure 165/97 mmHg (millimeters of mercury) (normal range systolic 95-120 and diastolic 59-81). MR lacked documentation that P1 had vital signs rechecked during his/her time in the Emergency Department or re-assessed by a registered nurse for any changes in medical or psychiatric conditions. 4. Interview with A1 (Chief Nursing Officer) on 01/23/2025 at approximately 1400 hours, confirmed that P1 medical record lacked documentation of patient re-assessment and/or vital signs being repeated, lacked documentation of having a sitter at the bedside, and lacked 15-minute monitoring of the patient safety checks for the duration P1 was in the ED. 5. In phone interview with N1 (Registered Nurse) on 01/27/2025 at 1030 hours verified that P1 did not have a sitter assigned on 01/11/2025 and		education to 100% of staff working by 1/27/25. After that date anyone not trained must complete education upon return to work but prior to providing care. No staff member will start their shift before education has been completed. Training and Education: Education includes: Columbia Suicide- Just In Time Tool (JIT), Patient Sitter Education , Suicide Risk Assessment and Interventions Columbia Protocol in Non- Behavioral Health Setting Policy. Education will also be provided during annual education /competencies. All new hires will be educated as part of the nursing orientation. Auditing Monitoring: Nurse administration/ designee will complete audits on all patients that screen high risk according to the Suicide Risk Assessment and Interventions Columbia Protocol and require a sitter, until 4 consecutive months with a 100% compliance rate (Patient sitter, continuous observation with Q15 documentation according to policy, Columbia Suicide Severity Rating Scale (C- SSRS) completed per shift, safe room checks and Risk level appropriateness) implemented 1/13/25. Ongoing internal audits will be conducted monthly by the nursing administration Leader/designee. Results will be reported to leadership safety	

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	should have.		huddle daily. Monthly report to the Quality Improvement Council, Medical Executive Committee and Governing Board. Responsible: Chief Nursing Officer	
S 0000 Bldg. 00				
	This visit was for the investigation of a State Licensure hospital complaint. Complaint Number: IN00451400 Deficiencies related to the allegations are cited. (S0930) Survey Date: 01/22/2025, 01/23/2025, and 01/27/2025 Facility Number: 005033 QA: 1/29/2025	S 0000	In response to the Rule citation the Leadership team developed and implemented this plan of Correction including policy reviews, revisions to process training and education for staff, and incorporation of an on-going audit and monitoring of plan .-S 930	
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, nursing services failed to assess patient and/or vital signs every 4 (four) hours, failed to document 15-minute monitoring safety checks, and failed to provide a sitter at the bedside for 1 of 10 patient (P1) medical records reviewed.	S 0930	#1 Action Taken: The ED Assessment and Reassessment policy was reviewed and no changes were required. Documentation flow was reviewed in the EMR and no changes were required. It was	02/26/2025

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	Findings include: 1. Facility policy titled "ED Assessment and Reassessment", revision date 09/24/2024. To provide guidelines for standardizing the frequency of assessing and reassessing of patients that present in the emergency department including patients triaged and in the ED waiting area. Vital signs will be recorded every four hours or at a minimum on admission and at time of discharge and as needed by the patients condition. 2. Facility policy titled "Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting", revision date: 06/08/2022, indicated All adolescent and adult patients who present for care will be screened for suicide ideation and behavior using the Columbia Protocol (Columbia-Suicide Severity Rating Scale (C-SSRS). On page 6, Table 1: Patient Safety Measures and Interventions Based on Screening Responses, Level of Risk: High- Initiate continuous observation (1:1 or in dedicated, secured, ligature resistant area or room), - RN to notify MD and MD to order Mental Health Professional face-to-face consult before leaves the area/unit, - All staff to use communication/de-escalation techniques, - If family/significant other with patient: Nurse to provide "Support Person Education", RN to Re-assess suicidal risk and need for suicidal precautions if there is an observed or stated change in behavior. Registered Nurse observe patient every 15 minutes and utilize the Frequent Observation Flow Sheet. Registered Nurse observe patient every 15 minutes and utilize the Frequent Observation Flow Sheet. 3. Review of P1 medical record indicated: a. Patient was admitted to the facility on		determined that it was non-compliance with the policy and education was provided to all staff members. Future follow up will be progressive discipline. Auditing and Monitoring: ED Assessment and Reassessment audits will be completed. A minimum of 50 ED patients per month will be audited from ESI 2 and 3 acuity ratings until there is 100% compliance for 4 consecutive months. Thereafter, ongoing internal audits will be conducted by the ED Department Leader/designee. All results will be reported to the leader safety huddle daily. The results will be reported to the Quality Improvement Council, Medical Executive Committee and Governing Board monthly. Responsible: Chief Nursing Officer #2- Actions Taken: The educator provided the Behavioral Health training and education to 100% of staff working by 1/27/25. After that date anyone not trained must complete education upon return to work but prior to providing care. No staff member will start their shift before education has been completed. Training and Education: Education includes: Columbia Suicide- Just In Time Tool (JIT), Patient Sitter Education , Suicide Risk Assessment and	

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	01/10/2025 for suicidal ideation. Columbia-Suicide Severity Rating Scale (C-SSRS) was completed on P1 indicated patient to be at a high risk for suicide. MR lacked documentation of completed 15-minute checks and lacked documentation of sitter at bedside while a patient at facility. b. Initial Medical Screen dated 01/10/2025 at 1620 hours indicated P1 was assessed by the triage nurse vital signs: pulse 84 bpm (beats per minute) (normal range 60-100 bpm), respiratory rate 16 brpm (breaths per minute) (normal range 10-21 brpm), blood pressure 165/97 mmHg (millimeters of mercury) (normal range systolic 95-120 and diastolic 59-81). MR lacked documentation that P1 had vital signs rechecked during his/her time in the Emergency Department or re-assessed by a registered nurse for any changes in medical or psychiatric conditions. 4. Interview with A1 (Chief Nursing Officer) on 01/23/2025 at approximately 1400 hours, confirmed that P1 medical record lacked documentation of patient re-assessment and/or vital signs being repeated, lacked documentation of having a sitter at the bedside, and lacked 15-minute monitoring of the patient safety checks for the duration P1 was in the ED. 5. In phone interview with N1 (Registered Nurse) on 01/27/2025 at 1030 hours verified that P1 did not have a sitter assigned on 01/11/2025 and should have.		Interventions Columbia Protocol in Non- Behavioral Health Setting Policy. Education will also be provided during annual education /competencies. All new hires will be educated as part of the nursing orientation. Auditing Monitoring: Nurse administration/ designee will complete audits on all patients that screen high risk according to the Suicide Risk Assessment and Interventions Columbia Protocol and require a sitter, until 4 consecutive months with a 100% compliance rate (Patient sitter, continuous observation with Q15 documentation according to policy, Columbia Suicide Severity Rating Scale (C- SSRS) completed per shift, safe room checks and Risk level appropriateness) implemented 1/13/25. Ongoing internal audits will be conducted monthly by the nursing administration Leader/designee. Results will be reported to leadership safety huddle daily. Monthly report to the Quality Improvement Council, Medical Executive Committee and Governing Board. Responsible: Chief Nursing Officer	