

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/26/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NORTHWEST HEALTH- PORTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 EAST US HWY 6</b> <b>VALPARAISO, IN 46383</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) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State licensure hospital complaint investigation.</p> <p>Complaint Number: IN00418437 - No deficiencies related to allegations are cited.</p> <p>Date of Survey: 2/26/2024</p> <p>Facility Number: 005033</p> <p>Northwest Health - Porter is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital licensure rules, in regard to the investigation of complaint IN00418437.</p> <p>QA: 3/1/2024</p>	S 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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