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 06/02/2021

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 the investigation of a state licensure hospital complaint. Complaint Number: IN00240418 Unsubstantiated: Lack of sufficient evidence. Survey Date: 06/02/2021 Facility Number: 005033 Northwest Health-Porter is in compliance with 410 IAC 15-1.5-5, Physician Services, and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules. QA: 6/22/2021	S 000		