

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/02/2022
NAME OF PROVIDER OR SUPPLIER NORTHWEST HEALTH-LA PORTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1331 STATE STREET LA PORTE, IN 46350		
(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>INITIAL COMMENTS</p> <p>This visit was for a State licensure hospital complaint investigation.</p> <p>Complaint Number: IN00260629</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Dates of Survey: 12/1/2022 to 12/2/2022</p> <p>Facility Number: 005006</p> <p>Northwest Health - Laporte is in compliance with 410 IAC 15-1.5-5, Medical Staff, 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules.</p> <p>QA: 12/12/2022</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE