STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005006	A. BUILDING: _____ B. WING _____	C 11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTH-LA PORTE	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	INITIAL COMMENTS This visit was for a State licensure hospital complaint investigation. Complaint Number: IN00294007 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 11/9/2021 Facility Number: 005006 Northwest Health - Laporte is in compliance with 410 IAC 15-1.5-5, Medical Staff, 410 IAC 15-1.5-6, Nursing Service, and 410 IAC 15-1.5-10, Utilization Review & Discharge Planning, Hospital Licensure Rules. QA: 11/15/2021	S 000		