

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005786	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/20/2020
NAME OF PROVIDER OR SUPPLIER ST MARY MEDICAL CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 S LAKE PARK AVE HOBART, IN 46342		
(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 licensure review of negative pressure patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP.</p> <p>Facility Number: 005786</p> <p>Date Of Survey: 8/20/2020</p> <p>The following patient rooms at St. Mary Medical Center, Inc were successfully verified as negative pressure: OB (Obstetrics) Department - Rooms: 139 and 140. 2-West Unit - Rooms: 206, 207, 208, 209, 210, 211, 212, 213, 215, 216, 217, 218, 219, 220 and 221. ICU (Intensive Care Unit) - Rooms: 271, 272, 273, 274, 275, 276, 277, 278, 279, 282, 283, 284, 285, 286, 287, 288, 289 and 290.</p> <p>The following patient rooms failed to be successfully verified as negative pressure: None.</p> <p>QA: 8/28/20</p>	S 000		

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

TITLE

(X6) DATE