

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005786</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/25/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST MARY MEDICAL CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1500 S LAKE PARK AVE HOBART, IN 46342</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 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: 02/25/2022</p> <p>The following patient rooms at St Mary Medical Center were successfully verified as negative pressure:</p> <p>1st floor - Labor and Delivery - Rooms: 137 and 138.</p> <p>The following patient rooms failed to be successfully verified as negative pressure: None.</p> <p>QA: 3/1/2022</p>	S 000		

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