STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005786	A. BUILDING: _____ B. WING _____	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY MEDICAL CENTER INC	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	INITIAL COMMENTS This visit was for a licensure review of negative pressure patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP. Facility Number: 005786 Date Of Survey: 1/12/2021 The following patient rooms at St. Mary Medical Center, Inc were successfully verified as negative pressure: 3-East Unit - Outpatient Infusion Center - Rooms: 335, 336, 337, 338, 339, 340 and 341. Clinical Decision Unit - Rooms: 101, 102, 103, 104, 105, 106, 109 and 110. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 1/27/21	S 000		