

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 03/18/2015
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NAME OF PROVIDER OR SUPPLIER ST MARY MEDICAL CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 S LAKE PARK AVE HOBART, IN 46342
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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>INITIAL COMMENTS</p> <p>This survey was for the investigation of one State complaint.</p> <p>Complaint number: IN 00152657 Unsubstantiated; lack of sufficient evidence</p> <p>Date of Survey: 03/18/2015</p> <p>Facility number: 005786</p> <p>St. Mary Medical Center, Inc. is in compliance with 410 IAC 15-1.5-5, Medical Staff Services and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules</p> <p>QA: cjl 03/27/15</p>	S 000		

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