Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005047	A. BUILDING: ________ B. WING ________	**01/19/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IU HEALTH BLOOMINGTON HOSPITAL	**601 W SECOND ST BLOOMINGTON, IN 47403**

(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 patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP and negative pressure patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP. Facility Number: 005047 Survey Date: 01/19/2021 The following patient rooms were converted/repurposed: Rooms 2406-1, 2406-2 and 2406-3, sleep lab rooms, were coverted to in-patient hospital patient rooms. The following patient rooms were successfully verified as negative pressure: 24-2, 2401, 2402, 2403, 2406-2, 2406-3, 2821, 2822, 2908, 2909, 4410, and 4411. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 2/1/21	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE