

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2023
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NAME OF PROVIDER OR SUPPLIER IU HEALTH BLOOMINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2651 EAST DISCOVERY PARKWAY BLOOMINGTON, IN 47408
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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 visit was for the investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00395131 -No deficiencies related to the allegations are cited.</p> <p>Survey Date: 09/11/2023</p> <p>Facility Number: 005047</p> <p>IU Health Bloomington Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules in regard to the investigation of complaint IN00395131.</p> <p>QA: 9/21/2023</p>	S 000		

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