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 _____	06/18/2020

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. Facility Number: 005047 Survey Date: 6/18/2020 The following rooms were converted from Rehabilitation Rooms to Medical-Surgical/Progressive Care Rooms: 2201D, 2201W, 2202D, 2202W, 2203D, 2203W, 2204, 2205, 2206, 2207 and 2208. QA: 6/23/20	S 000		