| 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 _____ | C 01/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| IU HEALTH BLOOMINGTON HOSPITAL | 2651 EAST DISCOVERY PARKWAY BLOOMINGTON, IN 47408 |

| (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<br><br>This visit was for investigation of a state licensure hospital complaint.<br><br>Complaint Number: IN00421494 - No deficiencies related to the allegations are cited.<br><br>Date of Survey: 01/25/24<br><br>Facility Number: 005047<br><br>IU Health Bloomington Hospital is in compliance with 410 IAC 15-1.5-10, Utilization Review and Discharge Planning Services, in regard to the investigation of complaint IN00421494.<br><br>QA: 2/9/2024 & 2/12/2024 | S 000 | | |