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 _____	12/02/2020

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 and negative pressure patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP. Facility Number: 005047 Survey Date: 12/2/20 The following patient rooms were converted: Rooms 2101, 2102, 2103, 2104 and 2105 in-patient rehabilitation rooms were converted to in-patient hospital patient rooms. The following patient rooms were successfully verified as negative pressure: 4211 The following patient rooms were successfully verified as negative pressure by use of field test: 4208, 4202, 3109, 3101, 3106, 3206, 3209, 3211, 3509, 3511, 3512, 3513, 3514, 2302, 2303, 2301. The rooms lacked a visual pressure monitoring mechanism indicating the air pressure status at all times. The following patient rooms failed to be successfully verified as negative pressure: 4209 (A1 indicated the room number was submitted in error and verified this was not an isolation negative pressure room). QA: 12/4/20	S 000		