

Indiana State 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 02/25/2019
NAME OF PROVIDER OR SUPPLIER IU HEALTH BLOOMINGTON HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00272298</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date of Survey: 02/25/2019</p> <p>Facility Number: 005047</p> <p>Indiana University Health Bloomington Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.</p> <p>QA: 3/28/19</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE