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 _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSF	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 one hospital complaint. Complaint IN00202701 Unsubstantiated: Lack of sufficient evidence. Survey date: July 20, 2017 Facility number: 005047 Indiana University Health Bloomington Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff services, Hospital Licensure Rules. QA: 10/4/17	S 000		