

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/26/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>IU HEALTH BLOOMINGTON HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 W SECOND ST BLOOMINGTON, IN 47403</b>
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(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><b>INITIAL COMMENTS</b></p> <p>This visit was for one State hospital complaint investigation.</p> <p>Complaint number: IN00249468 Unsubstantiated: lack of sufficient evidence.</p> <p>Survey date: 4/26/18</p> <p>Facility Number: 005047</p> <p>Indiana University Health Bloomington Hospital is in compliance with 410 IAC 15-1.5-6 Nursing Services, Hospital Licensure Rules.</p> <p>QA: 6/11/18</p>	S 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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