

Indiana State Department of Health

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| 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 07/07/2016 |
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| NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSF | STREET ADDRESS, CITY, STATE, ZIP CODE 601 W SECOND ST BLOOMINGTON, IN 47403 |
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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 |
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| S 000 | <p>INITIAL COMMENTS</p> <p>This visit was for State investigation of a complaint.</p> <p>Complaint #IN00183740 Substantiated; No deficiency related to allegation cited.</p> <p>Survey Date: 7/7/16</p> <p>Facility Number: 005047</p> <p>Indiana University Health Bloomington Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-6, Nursing Service.</p> <p>QA: 9/20/16 jlh</p> | S 000 | | |

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