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 _____	09/18/2017

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 the investigation of two state hospital complaints. Complaint IN00218333 Unsubstantiated: Lack of sufficient evidence. Complaint IN00224239 Unsubstantiated: Lack of sufficient evidence. Survey date: September 20, 2017 Indiana University Health Bloomington is in compliance with 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules. QA: 11/27/2017	S 000		