STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012132	A. BUILDING: _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF FORT WAYNE	2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805

(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 Facility Number: 012132 Type of Survey: State Licensure Off Site Joint Commission Accreditation Survey Date of Joint Commission On Site Survey - Hospital full survey 02/22/2017-02/24/2017 Date of ISDH off site review - 04/16/2018 Based on review of the May 22-24, 2017, Joint Commission Accreditation Survey Report, it has been determined that Vibra Hospital of Fort Wayne meets the requirements for Hospital Licensure in Indiana for 2017.	S 000		