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 _____	01/04/2017

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 This visit was for the investigation of one hospital licensure complaint. Complaint Number: IN00203685; Substantiated; No deficiency cited related to the allegations. Facility Number: 012132 Date: 1/4/17 Vibra Hospital of Fort Wayne is in compliance with 410 IAC 15-1.5-2, Infection Control, Indiana Hospital Licensure Rules. QA: 4/28/17 jlh	S 000		