STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING _____ B. WING _____	C 05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND POINTE HEALTH CAMPUS	**1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00430791, IN00432448, IN00433144, and IN00433680. Complaint IN00430791- No deficiencies related to the allegations are cited. Complaint IN00432448- No deficiencies related to the allegations are cited. Complaint IN00433144- No deficiencies related to the allegations are cited. Complaint IN00433680- No deficiencies related to the allegations are cited. Survey dates: May 2 and 3, 2024. Facility number: 000547 Provider number: 155775 AIM number: 100267440 Census Bed Type: SNF/NF: 38 SNF: 21 Residential: 56 Total: 115 Census Payor Type: Medicare: 7 Medicaid: 38 Other: 14 Total: 59 Cumberland Pointe Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING _____ B. WING _____	C 05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND POINTE HEALTH CAMPUS	**1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906**

(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) COMPLETION DATE
F 000	Continued From page 1 Investigation of Complaints IN00430791, IN00432448, IN00433144, and IN00433680. Quality review was completed on May 9, 2024.	F 000		