STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNCIE ESTATES SENIOR LIVING	1601 N MORRISON RD, MUNCIE, , 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 467140. Intake 467140 - State deficiencies related to the allegations are cited at R0044. Survey date: January 20, 2026 Facility number: 010886 Residential Census: 65 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 30, 2026.	R 0000	ROOO This plan of correction is not to be interpreted as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies dated 1/20/2026. It is a submission of our ongoing efforts to comply with regulatory requirements. We remain committed to the delivery of quality health care services and will continue to make changes and improvements in line with than objective.	
R 0044	Residents' Right - Deficiency 410 IAC 16.2-5-1.2(r)(1-5) (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident	R 0044	ROO44	02/02/2026

	to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances		The Regional Director of Health Services (RDHS) reviewed and re-educated the Health Facility Administrator (HFA), Executive Director on Indiana discharge regulations and residents rights related to proper discharge on 2/9/2026. The Health Facility Administrator/ED or designee will collaborate with the Regional Team and Ombudsman to review all proposed discharges prior to execution to ensure the reason for discharge meets regulatory requirements and that resident rights are upheld. The Health Facility Administrator/ED reviewed and discussed this deficiency with the Quality Assessment and Performance Improvement team (QAPI) on 2/10/2026 during the monthly scheduled Clinical Quality Measures and Continuous Quality Improvement (CQM/CQI) meeting. Discharge compliance will be added as an ongoing monitoring item.	

specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following:

(A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B).

(B) Any physician when transfer or discharge is necessary under subdivision (4)(D).

Based on interview and record review, the facility failed to protect a resident's right to be free from discharge from the facility without appropriate reason for issuance of a 30-day notice for 1 of 1 resident reviewed for 30-day notices (Resident B).

Findings include:

Review of a 30- day notice letter, issued to Resident B's son and dated 12/3/25, indicated that it served as a notice of transfer or discharge to a facility of choice. The reason for the transfer or discharge was due to the continued concerns of interference with care, staff were uncomfortable with how the son discussed things with them that were not pertinent to their position, and continued concerns about recent conversations regarding private areas.

The notice lacked

documentation that Resident B's needs could not be met in the facility, the resident's health had improved to where she no longer needed services, or the health or safety of others were at risk.

Resident B's clinical record was reviewed on 1/20/26 at 10:09 a.m. Diagnoses included unspecified dementia, weakness, and nutritional deficiency.

A Saint Louis University Mental Status (SLUMS) cognitive evaluation, dated 11/13/24, indicated she had severe cognitive impairment.

During an interview, on 1/20/26 at 12:03 p.m., the Administrator, with the Director of Nursing (DON) present, indicated that the 30-day notice criteria was met by the resident's son, who prevented staff from providing care necessary for the resident's safety and welfare. The DON indicated that the son restricted staff from assisting with Activities of Daily Living (ADLs), including toileting, dressing, nutrition, and attending meals in the dining room while he was in the facility. He would not allow the resident to sit in the dining room or establish a routine. He changed the resident's medications and arranged out-of-state telehealth visits. He also impeded

emergent treatment; he did not want the resident sent to the emergency room without his permission and insisted on taking her himself during an episode of active rectal bleeding. Due to the son working in another city, the resident would have had to wait approximately 30 minutes for him to transport her and on one occasion he wanted to delay care until after church services so he could take her to a hospital in the city he lived in. The DON also indicated that the son locked the resident's apartment door during his visits and did not want staff entering the room. The son impeding on the resident's care resulted in increased resident aggression, noncompliance, and behavioral changes when he was present.

During an interview, on 1/20/26 at 2:05 p.m., the Administrator indicated they did not have a policy on the 30-day notices and they referred to the facility's Resident Admission Agreement.

The current facility's admission agreement titled "Assisted Living Resident Admission Agreement," dated 11/2021 and provided by the Administrator on 1/20/26, indicated the following: " ...Termination of rental agreement and refunds ...C. Termination by Facility (without notice). The Facility may terminate this Agreement

without prior notice in an emergency situation for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered ...."

This citation relates to Intake IN00467140.

Based on interview and record review, the facility failed to protect a resident's right to be free from discharge from the facility without appropriate reason for issuance of a 30-day notice for 1 of 1 resident reviewed for 30-day notices (Resident B).

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREDawn Beeman	TITLEHealth Facility Administrator	(X6) DATE02/10/2026