STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/19/2024

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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00425490 completed on January 23, 2024. Complaint IN00425490 - Corrected. Survey dates: February 19, 2024 Facility number: 010886 Residential Census: 45 Muncie Estates Senior Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00425490. Quality review completed February 20, 2024. This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00425490 completed on January 23, 2024.	R 0000		

	Complaint IN00425490 - Corrected. Survey dates: February 19, 2024 Facility number: 010886 Residential Census: 45 Muncie Estates Senior Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00425490. Quality review completed February 20, 2024.			

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 SIGNATURE	TITLE	(X6) DATE