STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/11/2025

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 IN00464179. Intake IN00464179 - State deficiencies related to the allegations are cited at R0052. Survey date: September 11, 2025 Facility number: 010886 Residential Census: 66 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed September 22, 2025.	R 0000	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 9/11/2025. It is a submission of our on-going efforts to comply with regulatory requirements. We have outlined specific actions in response to identified issues. We remain committed to the delivery of quality health care services and will continue to make changes and improvements in line with that objective.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	**R 052 410 IAC 16.2-5-1.2 (v) 1-6 Residents Rights** There was a potential to affect 27 of 27 residents.	10/10/2025

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure interventions were in place to protect a resident's right to be free from elopement for 1 of 3 cognitively impaired residents reviewed for elopement by failing to provide supervision and secure windows on a secured memory care unit. (Resident D) This deficient practice resulted in a cognitively impaired resident being found, unsupervised, off facility property and had the potential to affect 27 of 27 cognitively impaired residents living in the facility. Findings include: Resident D's clinical record was reviewed on 9/11/25 at 1:31 p.m. Diagnoses included cognitive decline, hyperlipidemia, and fatigue. A current service plan, dated 8/14/25, indicated the resident was severely cognitively impaired and a moderate elopement risk.		Correction of Cited Deficiency: The Director of Nursing/Designee will complete all new elopement assessments on all residents admitted on or before 9/11/25. Completed: 10/10/25 Audited all exit doors to ensure working properly and alarming. Completed: 9/11/25 Call placed to Eric Brown, Chief Inspector of fire department and Jeff Gabbard, Indiana State Fire Marshall for resolution approval. They both agreed to following: All windows were secured immediately with brackets to prevent from tipping in. Completed: 9/11/25 Elopement book is kept on all residents with photo, emergency and medical history. Elopement book is updated per admission and discharge reviewing monthly in QAPI (Quality Assurance) meeting.	

	A nurse's note, dated 8/18/25 at 2:06 p.m., indicated the resident was last seen in the memory care dining room at 10:50 a.m. The nurse was alerted to the elopement at 11:37 a.m. A maintenance assistant witnessed an elderly person crossing the street towards another facility. Review of a facility reportable incident dated 8/18/25 indicated Resident D was observed by a maintenance associate walking across the street at another facility. Windows in the facility opened six inches but could be unlocked and tilted inward. It was determined that the resident unlocked the window at the front of the building, which was not fenced, and eloped. Review of an email provided after entrance conference, dated 8/20/25 at 11:15 p.m., indicated the resident eloped at 11:37 a.m. and returned to the facility at 11:50 a.m. He was found approximately one thousand feet from the facility. During a tour of Resident D's room on 9/11/25 at 10:02 a.m., a low bed was pushed against the far west wall. Metal brackets were observed on both sides of the windows. During an observation on 9/11/25 at 10:17 a.m., Resident D was sitting in the common		Completed: 9/19/25 and ongoing. Monthly elopement drills are completed with staff involvement and varies quarterly per shifts. Reviewed monthly in QAPI meeting. Completed: 9/30/25 and ongoing. Assessments are completed on admission, with change in condition and every 6 months per policy. Completed: 9/12/25 Elopement in-service was completed at all staff meeting on 9/12/2025.	

area at the front of the memory care building. He then stood up and independently ambulated out of the area with a CNA following behind him.

During an interview on 9/11/25 at 10:19 a.m., the Maintenance Assistant indicated his first interaction with Resident D was seeing him in the main sitting room at the front of the memory care building. During an unspecified time, the maintenance assistant was taking trash to dumpsters between the memory care and main buildings. He observed an elderly gentleman walking towards the street, close to where the transport bus parks at the front of the main building. He gave a description to another staff member, but did not approach the gentleman.

During an interview on 9/11/25 at 10:23 a.m., the ADON indicated Resident D was very anxious on admission and it was difficult to keep him occupied. He would often wonder around the memory care building searching for his wallet and phone. She indicated the resident went into another resident's room at the front of the memory care building and climbed out a window. She was told about the elopement after the resident returned.

During an interview on 9/11/25

at 10:27 a.m., CNA 4 indicated Resident D was quiet and kept to himself. He often wandered around the building, looking for a bathroom.

During a telephone interview on 9/11/25 at 11:37 a.m., Resident D's representative indicated the resident admitted to the facility when he was deemed to no longer be safe at home. She noted a previous history of strokes and poor short-term memory. The representative was made aware of the elopement and indicated the resident exited the memory care building through a window and was found near a local department store.

During a distance observation, via vehicle on 9/11/25 at 12:02 p.m., the distance from the parking lot to the stop sign where the resident was found was one thousand fifty-six (1056) feet.

During an interview on 9/11/25 at 1:05 p.m., the Administrator indicated Resident D was very compliant and not exit seeking when he was admitted on 8/14/25. An employee briefly saw Resident D in the memory care common area, went outside to take out some trash, and then saw the resident already across the street walking on the sidewalk. The employee then ran back inside

	and told the charge nurse, who drove to a four-way stop at the corner of Morrison Road and Petty Road. During a phone interview on 9/11/25 at 1:31 p.m., Home Health Aide (HHA) 5 indicated Resident D was often seen wandering the hallways of the memory care building, searching for a bathroom. The resident frequently wandered the hallway where the elopement occurred. He was easily directed. Two aides and a nurse worked on the memory care unit the day of the elopement instead of the usual three aides and a nurse. HHA 5 indicated she was on break from 10-10:30 a.m. and heard about the elopement when she returned from break.			

During an interview on 9/11/25 at 1:58 p.m., HHA 6 indicated Resident 6 enjoyed wandering the halls of the memory care building several times a week. The resident had mentioned to her, close to his admission date, that he wished to leave the facility. On the day of the elopement, she had been assigned to work on a different hallway, but assisted with searching for Resident 6 when it was discovered he was missing. HHA 6 last saw Resident 6 at an unspecified time prior to lunch. He was exiting seeking during his first week of admission.

A current facility document titled, "Wandering and Elopement Prevention Plan Program", provided by the Administrator on 9/11/25 at 3:11 p.m. indicated the following, " ...The purpose of this policy is to provide a system for identification of residents at risk for unsafe wandering and elopement, provide a program of supervision and interventions to minimize risk of resident elopements and elopement attempts, and provide team member education in effective wandering and elopement management through in-services and elopement drills ...1. A plan to reduce the potential of elopement will be developed with input from the resident's legal representative and documented on the

	individualized Service Plan/Care plan such as the following but are not limited to: A. New residents are to be closely monitored and, if possible, have apartments away from exit doors and closer to staff area. B. Institute whereabout checks so staff can account for all residents at risk for elopements on each shift at regular intervals. C. Instruct staff to maintain a visual line of sight of exit doors, particularly during shift change, mealtimes, and emergencies, as these are times when residents may be able to exit the Community unnoticed while staff attention is diverted ...." This citation relates to Intake IN00464179.			

Based on observation, interview, and record review, the facility failed to ensure interventions were in place to protect a resident's right to be free from elopement for 1 of 3 cognitively impaired residents reviewed for elopement by failing to provide supervision and secure windows on a secured memory care unit. (Resident D) This deficient practice resulted in a cognitively impaired resident being found, unsupervised, off facility property and had the potential to affect 27 of 27 cognitively impaired residents living in the facility.

Findings include:

Resident D's clinical record was reviewed on 9/11/25 at 1:31 p.m. Diagnoses included cognitive decline, hyperlipidemia, and fatigue.

A current service plan, dated 8/14/25, indicated the resident was severely cognitively impaired and a moderate elopement risk.

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another facility.

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Review of an email provided after entrance conference, dated 8/20/25 at 11:15 p.m., indicated the resident eloped at 11:37 a.m. and returned to the facility at 11:50 a.m. He was found approximately one thousand feet from the facility.

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PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREDawn Beeman	Administrator	