STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/06/2026

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 468410. Intake 468410 - State deficiencies related to the allegations are cited at R0064. Survey dates: March 5 and 6, 2026 Facility number: 010886 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 12, 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 3/6/26. 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 that objective.	
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for	R 0064	**R 064 410 IAC 16.2-5-1.2(hh) Residents Rights** Upon investigation of the missing medication, an investigation was conducted immediately.	03/22/2026

	investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from misappropriation of controlled substances for 1 of 3 residents reviewed for misappropriation. (Resident B) This had the potential to affect 34 of 64 residents who received controlled medications administered by staff from the four facility medication carts. Finding includes: Resident B's clinical record was reviewed on 3/5/26 at 3:12 p.m. Diagnoses included vascular dementia, malignant neoplasm of the prostate, and osteoarthritis. A current, 10/1/25, Service Plan indicated Resident B required hospice services. Staff administered the resident's medication. A current physician order, dated 12/16/25, included morphine sulfate 100 milligrams (mg)/5 milliliter (ml), administer 0.25 ml by mouth as needed every 6 hours for pain. The Medication Administration Record indicated Resident B		34 of 64 residents had the potential of being affected. **Immediate Actions Taken** • Medication carts and medication room was thoroughly checked for missing medication by the Charge Nurse and Executive Director on 3/6/26. • Police Department, State Department of Health, Hospice and Regional Team notified on 3/6/26. • Narcotic audit and count was completed to identify and further missing doses. This was completed by two licensed nurses on 3/6/26. • Missing narcotic was replaced. ED/HFA spoke with Hospice Nurse on 3/6/26. • On 3/11/26 Regional Director of Health Services in-serviced 100% of nurses and QMA's on Residential Regulations for medication management, facility policies and procedures for medication management, narcotics, narcotic counts, narcotic storage, process for narcotic destruction, key possessions and nurses'	

	received the following doses of morphine: On 12/24/25 at 8:16 p.m. - morphine 0.25 ml On 1/8/26 at 10:12 p.m. - morphine 0.25 ml On 1/27/26 at 3:25 p.m. - morphine 0.25 ml On 2/7/26 at 3:05 p.m. - morphine 0.25 ml On 2/8/26 at 4:30 p.m. - morphine 0.25 ml An Intake/Quantity report indicated 30 ml of morphine was received on 12/18/25 at 5:05 a.m. On 3/2/26 at 10:45 p.m., 28.75 ml of morphine was reported missing by LPN 8. A review of the facility investigation file, provided by the Administrator on 3/6/26 at 9:57 a.m., included the following: A handwritten Investigation Witness Statement from LPN 8, dated 3/3/26, indicated she took the keys from LPN 6 and started doing a narcotic count while LPN 6 spoke with the police about another situation. LPN 8 approved the count and LPN 6 signed off on the count, but the two nurses did not count together. LPN 8 was aware when she signed off and		station to remain locked and always closed when nurse/QMA not present. The automatic door closure was placed on the door 3/22/26 by the Maintenance Director. • New narcotic count sheets were put into place on 3/13/26. Narcotic count was removed for EMAR system to prevent missing count. • HSD/Designee will review narcotic counts weekly during med cart audit. This will be an added task on-going moving forward to weekly audit. • HSD/Designee will conduct random shift change audits to verify count is being completed per policy. • HSD/Designee will review pharmacy narcotic sheets against in house documentation for any discrepancies. • The results of these audits will be reported to the QAPI committee during CQI meetings.	

accepted the keys, she had verified the count was correct and the cart became her responsibility. The cart and refrigerator were rechecked without success.

A handwritten Investigation Witness Statement from LPN 6, dated 3/3/26, indicated she could not verify and say 100% when she last saw the missing bottle of morphine because she never administered the morphine to Resident B. Staff have been " laxed " in counting the liquid controlled medications because most of them were administered as needed. For shift-to-shift controlled medication counts, they only counted the pills because most of the liquid medications were not administered on their shift. She knew this practice was wrong and careless.

A handwritten Investigation Witness Statement from LPN 7, dated 3/3/26, indicated LPN 7 last worked on 3/1/26 from 2:00 p.m. to 10:00 p.m. She knew for certain LPN 7 counted Resident B's morphine with LPN 6 and LPN 9 at the exchange of the medication carts. The resident's morphine was present on that day.

A telephone Investigation Witness Statement from LPN 9, dated 3/4/26, indicated the staff have all been guilty and " laxed

	" counting the liquid controlled medications that were not used very often. They did not count the liquid narcotics during exchange of the medication carts because the amounts did not change since they were administered on an as needed basis. LPN 9 was aware their medication reconciliation process was incorrect. A facility Incident Report to the Indiana Department of Health, dated 3/3/26 at 7:45 a.m., indicated Resident B's bottle of morphine (opiate pain medication) was missing during a narcotic count and reported missing to the DON immediately. An investigation was ongoing. Resident B's last dose of morphine was received on 2/8/26. During an interview on 3/5/25 at 12:05, QMA 5 indicated they recently had a missing bottle of morphine from Memory Care medication cart 1. Controlled medications in the medication carts were required to be counted together by the off-going and on-coming staff members each time the medication cart switched hands. The Memory Care Unit medication carts contained a spare set of keys in the Memory Care medication cart narcotic boxes for the Assisted Living (AL) medication carts and			

narcotic drawers. Likewise, a spare set of keys to the Memory Care medication carts and narcotic drawers were in the AL medication carts narcotic drawers. This gave additional staff members from another unit access to controlled medications they were not responsible for.

On 3/5/26 at 12:36 p.m., LPN 6 indicated she worked days shift on the Memory Care Unit on 3/2/26. When she arrived on the Memory Care Unit that morning, she found the keys to both Memory Care Unit medication carts in the nurse's station desk drawer with the door open. She thought she completed the shift-to-shift narcotic count alone that morning. The medication cart keys were often left by the night shift nurse, unsecured in the desk drawer, with the office door open so that days shift could get started when they arrived. At the end of her shift, LPN 6 was handling a different situation with a resident's family when LPN 8 was ready for shift-to-shift narcotic reconciliation at the end of the shift around 2:20 p.m. LPN 8 asked LPN 6 for the keys to Memory Care medication cart 1 and Memory Care medication cart 2 to start the narcotic reconciliation. LPN 6 signed into the electronic health record for the electronic medication

reconciliation and handed both medication carts' keys to LPN 8. LPN 8 counted both medication carts alone and co-signed to indicate her agreement with the count. LPN 8 never mentioned any discrepancies to LPN 6 before LPN 6 went home. At 10:14 p.m. the same day, LPN 8 called LPN 6 in a panic and explained the morphine for Resident B was missing. LPN 8 told LPN 6 she would call back, but no further calls were received.

During an observation on 3/5/26 at 12:59 p.m., a spare set of keys were in the Memory Care Unit medication cart 2 narcotic drawer. LPN 6 indicated the keys were a spare set for the AL medication cart. Anyone assigned to the medication cart 2 had access to keys including the narcotic drawer keys to another medication cart they were not assigned to.

During an interview on 3/5/26 at 1:06 p.m., QMA 5 indicated on 3/5/26 she came in to take over the Memory Care medication cart 1 and Memory Care medication cart 2 on days shift. The Memory Care nursing station door was open with both Memory Care Unit medication carts ' keys in the desk drawer and unsecured. They were accessible to anyone. This was not the first time the keys were

left unattended prior to her arrival for her shift. Medication cart keys must remain in possession of the staff member assigned to the medication carts. Unsecured medication cart keys left opportunities for unauthorized access to controlled medications.

On 3/5/26 at 1:36 p.m., LPN 4 indicated the spare keys to the Memory Care Unit medication carts and narcotic drawers were stored in one of the narcotic drawers of the AL medications carts. They were currently in the Assisted Living Unit medication cart 1. Whoever was assigned to medication cart 1 on the Assisted Living Unit had access to narcotics on the Memory Care Unit medication carts. This was an opportunity for drug diversion.

During an observation on 3/5/26 at 2:05 p.m., AL Unit medication cart 1 had a spare set of keys (4 keys divided by key rings) in the narcotic drawer for the Memory Care medication carts. During an interview, QMA 3 indicated the facility had been keeping the spare keys for the medication carts in the opposite unit narcotic drawer because staff had taken the keys home with them at times. The spare keys in the drawer had been there for approximately one month.

During an interview on 3/6/26 at

	1:02 p.m., the Administrator indicated the facility was unable to find Resident B's bottle of morphine containing 28.75 ml. The facility policy and protocol were not followed regarding counting liquid narcotics. All controlled medications were required to be counted at each exchange of the medication carts. The Memory Care Unit medication carts' keys had been left in the desk drawer unsecured at times on night shift. Spare sets of keys for the medication carts and narcotic drawers were kept in the opposite building medication carts. The availability of spare keys to medication carts and unsecured keys were opportunities for drug diversion. It was the facility's responsibility to ensure residents were protected from misappropriation. A current facility policy, dated 11/1/21, titled " Controlled Substance Diversion Prevention Plan," provided by the Administrator on 3/6/26 at 9:57 a.m., indicated the following: " Policy ... The community will follow established standards for the prevention plan, which aims to reduce the risk of controlled substance diversion within the community. The procedure contains standards for secure storage, controlled access, monitoring, and proactive reporting while maintaining			

	compliance with federal, state, and local regulations ... 3. Secure Storage ... A. Double-Locking System a. All controlled substances classified as Schedule II, III, or IV must be stored in a double-locked, separately keyed compartment within a secure, designated storage area ...c. Keys to the compartments are assigned to authorized personnel only, and access is logged to maintain a clear record of usage ... C. Storage Room Requirements a. Storage areas must be ... monitored, and inaccessible to unauthorized personnel. 4. Inventory Control and Monitoring A. Routine Counts a. At every shift change two (2) staff members must count and verify all controlled substances, with both individuals initialing the controlled substance log to confirm accuracy. B. During counts, staff must compare physical inventory with the documented amounts in the Individual Controlled Substance Records to ensure no discrepancies exist .... "			

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) DATE03/22/2026