STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100403	A. BUILDING: _____ B. WING _____	C 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERN TERRACE OF BOWLING GREEN, LLC	1030 SHIVE LANE BOWLING GREEN, KY 42101

(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) COMPLETE DATE
P 000	Initial Comments A Complaint Survey investigating KY00048033 was initiated on 02/18/2026 and concluded on 02/18/2026 with deficiencies cited.	P 000		
P 165	902 KAR 20:036 4(11)(b)7 Section 4. Administration And Operation Section 4. Administration and Operation. (11) Medical records. (b) Each record shall include: 7. Nurses' or staff notes indicating any changes in the resident's condition as changes occur; This requirement is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to document an event indicating a change for 1 of 4 sampled residents after an incident which resulted in Resident 1 (R1) leaving the facility without approval, and law enforcement locating him lost walking down the street after visiting a nearby store. The findings include: Review of the facility policy titled, "Wandering and Resident Rights," dated 04/22/2025, revealed a written report of any incident or accident involving a resident must be completed by the first staff person on the scene. If the first person on the scene was not trained to file an incident report, a verbal report will be given to a staff member knowledgeable in incident report filing. The	P 165		

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

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P 165	Continued From page 1	P 165		

document further revealed anytime a resident leaves the facility, a resident and/or person responsible shall sign a responsibility form and advise the facility of the time the resident would return. The policy further revealed it was the responsibility of the administrative staff to maintain and keep current, a list of residents that were potential wanderers or persons likely to vacate the premises without proper notification. It was the responsibility of the administrative staff to review the sign out document book for omissions or errors each day and pass this review verbally to a medication tech for use during shift reports. In the event of a missing person, it was important to make a note of the time of the notification and the person's name making the notification. A check of the sign out book and a check with the person's roommate or anyone who was believed to have any relevant information, should be completed. The staff should then immediately telephone the administrative person on duty. Administrative personnel would determine the accuracy of the missing report, and immediately notify the county sheriff's department, the city police department, and the rescue squad if appropriate.

Review of Resident 1 (R1's) "Admitting Record." revealed the facility admitted Resident 1 (R1) on 01/28/2025 with diagnosis of Anxiety, Hypertension, and Insomnia. Further review of (R1's) medical record Serious Mental Illness form completed on 04/22/2025 revealed the individual did not have a diagnosis of mental illness.

Record review of "Hourly Logs" revealed the facility failed to document (R1) leaving the facility and hourly checks completed by Med Tech 1, failed to document (R1) was out of the facility at 2:00 PM and 3:00 PM. The document on

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02/14/2026 stated (R1) was in the facility at 1:00 PM and marked "Out of Facility," at 2:00 PM and 3:00 PM and back in the facility at 3:30 PM. Med Tech 1 went to the hourly logs and documented (R1) was out of the facility at 2:00PM and 3:00 PM after (R1) was returned to the facility at 3:30 pm on 02/14/2026. During an interview with Med Tech 1 on 02/18/2026 at 12:15 PM, she confirmed that this documentation was completed after (R1) was returned to the facility.

Review of the facility "Incident Report," dated 02/14/2026, revealed the facility received a call from the local police department that a resident was at a local store and got lost coming back. An administrative follow up document dated 02/17/2026 stated that resident got turned around not knowing the area. The facility notified the guardian of (R1) of the incident.

During an interview with Med Tech 1 on 02/18/2026 at 12:15 PM she stated that on 02/14/2026, (R1) left the facility to buy cigarettes at a local store. Staff were unaware that (R1) had left the facility. Med Tech 1 was going to go to the patio to find R1 when she was stopped by another resident that needed to be cleaned up and showered. She stated that she failed to do hourly checks on (R1) after she had completed a resident shower. At 3:15 PM Med Tech 1 received a phone call from the administrator stating that police had called her at 3:10 PM and conveyed that the police had to respond to an anonymous complaint that there was a white male with long gray hair using a cane and walking in the roadway that appeared confused. Law enforcement stated that they made contact with a male that was identified as (R1) and that he walked to a local store to purchase cigarettes and was unable to recall where he came from. (R1) advised law

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enforcement that he had been walking for two hours. Law enforcement then contacted the administrator at Fern Terrace at 3:10 PM. Med Tech 1 further stated during an interview on 02/18/2026 at 1:30 PM that she was not aware at the time that (R1) had left the facility because she was busy with another resident. Med Tech 1 stated, "I am not sure what time it was but I think the police called at 3:15 PM."

During an interview with (R1) on 02/18/2026 at 1:00 PM, he stated he remembered when this event happened and that he just got turned around. (R1) stated that he was not familiar with the area. (R1) further stated that he came from Owensboro and he knew that city better and never had gotten lost. He was aware that he forgot to sign out and stated, "I will never do that again".

During a phone interview with the State Guardian of R1 on 02/18/2026 she stated that she had no concerns at all with the facility and the safety of (R1). She stated, he was the most mentally capable of all the residents she was assigned to as a guardian. She stated that the building in Bowling Green (Fern Terrace) was not officially open and that all the residents at the facility were just moved to that building temporarily after a fire in Owensboro. She also stated that she notified the facility after the incident that R1 was not to leave the facility again without supervision.

During an interview with the facility Administrator on 02/18/2026 at 10:00AM, she stated that their facility in Owensboro burned last year and a new facility was being built. She stated, "We were just in a hurry to get all residents somewhere after the fire". The residents were moved to Fern Terrace until they can return to their building in

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P 165	Continued From page 4 Owensboro in May of 2026. She stated that (R1) got lost because he was not familiar with the area. She stated on 02/14/2026 (R1) forgot to sign out when he left the building. He was later found by local law enforcement walking in the road and returned to the facility. The facility was not aware that (R1) was missing from the building and did not document his safety log check until after he was returned. The administrator stated all residents were supposed to sign out with the time, date, and where they were going when they leave the facility. The administrator stated they were having a Valentine party for the facility residents and didn't realize (R1) was gone until they went to his room to find him at 2:00 PM. When asked if she was aware that the guardian for (R1) requested that he always needed to have someone with him when he left the facility, she stated "yes". The administrator further stated that a negative outcome for a resident to wander off the property would be safety concerns. She stated, "I will put something in (R1's) chart that either a buddy or staff needs to always accompany him when he leaves the facility." This information was placed in the chart of (R1) by the Administrator for the first time on 02/18/2026 at 3:00 PM.	P 165		
P 210	902 KAR 20:036 5(1)(a) Section 5. Provision of Services Section 5. Provision of Services. (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to ensure that the resident's health care needs are met; 2. Supervision of self-administration of	P 210		

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P 210	Continued From page 5 medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide supervision and monitoring to ensure the residents health care needs are met for 1 of 4 sampled residents which resulted in Resident 1 (R1) leaving the facility without approval, and law enforcement locating him lost walking down the street after visiting a nearby store. The findings include: Review of the facility policy titled, "Wandering and Resident Rights," dated 04/22/2025, revealed a written report of any incident or accident involving a resident must be completed by the first staff person on the scene. The document stated a written report of any incident or accident involving a resident must be completed by the first staff person on the scene. If the first person on the scene was not trained to file an incident report, a verbal report will be given to a staff member knowledgeable in incident report filing. The document further revealed anytime a resident	P 210		

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P 210	Continued From page 6	P 210		

leaves the facility, a resident and/or person responsible shall sign a responsibility form and advise the facility of the time the resident would return. The policy further revealed it was the responsibility of the administrative staff to maintain and keep current, a list of residents that were potential wanderers or persons likely to vacate the premises without proper notification. It was the responsibility of the administrative staff to maintain and keep current, a list of residents that were potential wanderers or persons likely to vacate the premises without proper notification. It was the responsibility of the administrative staff to review the sign out document book for omissions or errors each day and pass this review verbally to a medication tech for use during shift reports. In the event of a missing person, it was important to make a note of the time of the notification and the person's name making the notification. A check of the sign out book and a check with the person's roommate or anyone who was believed to have any relevant information, should be completed. The staff should immediately telephone the administrative person on duty. Administrative personnel would determine the accuracy of the missing report, and immediately notify the county sheriffs department, the city police department, and the rescue squad if appropriate.

Review of Resident 1 (R1's) "Admitting Record." revealed the facility admitted Resident 1 (R1) on 01/28/2025 with diagnosis of Anxiety, Hypertension, and Insomnia. Further review of (R1's) medical record Serious Mental Illness form completed on 04/22/2025 revealed the individual did not have a diagnosis of mental illness.

Record review of "Hourly Logs" revealed the

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facility failed to document (R1) leaving the facility and hourly checks completed by Med Tech 1, failed to document (R1) was out of the facility at 2:00 PM and 3:00 PM. The document on 02/14/2026 stated (R1) was in the facility at 1:00 PM and marked "Out of Facility," at 2:00 PM and 3:00 PM and back in the facility at 3:30 PM. Med Tech 1 went to the hourly logs and documented (R1) was out of the facility at 2:00PM and 3:00 PM after (R1) was returned to the facility at 3:30 pm on 02/14/2026. During an interview with Med Tech 1 on 02/18/2026 at 12:15 PM, she confirmed that this documentation was completed after (R1) was returned to the facility.

Review of the facility "Incident Report," dated 02/14/2026, revealed the facility received a call from the local police department that a resident was at a local store and got lost coming back. An administrative follow up document dated 02/17/2026 stated that resident got turned around not knowing the area. The facility notified the guardian of (R1) of the incident.

During an interview with Med Tech 1 on 02/18/2026 at 12:15 PM she stated that on 02/14/2026, (R1) left the facility to buy cigarettes at a local store. Staff were unaware that (R1) had left the facility. Med Tech 1 was going to go to the patio to find R1 when she was stopped by another resident that needed to be cleaned up and showered. She stated that she failed to do hourly checks on (R1) after she had completed a resident shower. At 3:15 PM Med Tech 1 received a phone call from the administrator stating that police had called her at 3:10 PM and conveyed that the police had to respond to an anonymous complaint that there was a white male with long gray hair using a cane and walking in the roadway that appeared confused. Law enforcement stated

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that they made contact with a male that was identified as (R1) and that he walked to a local store to purchase cigarettes and was unable to recall where he came from. (R1) advised law enforcement that he had been walking for two hours. Law enforcement then contacted the administrator at Fern Terrace at 3:10 PM. Med Tech 1 further stated during an interview on 02/18/2026 at 1:30 PM that she was not aware at the time that (R1) had left the facility because she was busy with another resident. Med Tech 1 stated, "I am not sure what time it was but I think the police called at 3:15 PM."

During an interview with Med Tech 2 on 02/18/2026 at 12:45 PM she stated that she remembered the day that this incident happened and that Med Tech 1 had to pick up (R1) because he was lost. Med Tech 2 was aware of the policy that all residents are to sign out when they leave the facility.

During an interview with Cook 1, on 02/18/2026 at 01:00 PM, she stated that she heard staff members talking about the incident with (R1) and was not involved but she was working that day, 02/14/2026. She stated there was a book the residents had to sign out and back in from.

During an interview with Floor Aid 1, on 02/18/2026 at 1:15 pm, she stated that (R1) left the building without signing out and he got lost and police called the facility Administrator for someone to come to pick him up but didn't know what time. Foor Aid 1 stated (R1) he never had an issue like this before.

During an interview with (R1) on 02/18/2026 at 1:00 PM, he stated he remembered when this event happened and that he just got turned

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around. (R1) stated that he was not familiar with the area. (R1) further stated that he came from Owensboro and he knew that city better and never had gotten lost. He was aware that he forgot to sign out and stated, "I will never do that again".

During an interview with (R2) on 02/18/2026 at 1:15 PM he stated he had no concerns at all with facility and staff. He stated that anyone that left the facility had to sign out and list the time and the place they were going. He stated that he always let someone know in the med tech room or Administrator before leaving.

During an interview with (R3) on 02/18/2026 at 1:25 PM she stated that there was a book that everyone was supposed to sign when they leave the facility. She stated she had no concerns with the facility staff but was ready to go back home.

During an interview with (R4) on 02/18/2026 at 1:35 PM the resident stated you always sign out before you leave the building so staff will know where to find you if you get lost. The resident stated no concerns with staff or the facility but would rather be in the other building in Owensboro.

During a phone interview with the State Guardian of R1 on 02/18/2026 she stated that she had no concerns at all with the facility and the safety of (R1). She stated, he was the most mentally capable of all the residents she was assigned to as a guardian. She stated that the building in Bowling Green (Fern Terrace) was not officially open and that all the residents at the facility were just moved to that building temporarily after a fire in Owensboro. She also stated that she notified the facility after the incident that R1 was not to

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P 210	Continued From page 10 leave the facility again without supervision. During an interview with the facility Administrator on 02/18/2026 at 10:00AM, she stated that their facility in Owensboro burned last year and a new facility was being built. She stated, "We were just in a hurry to get all residents somewhere after the fire". The residents were moved to Fern Terrace until they can return to their building in Owensboro in May of 2026. She stated that (R1) got lost because he was not familiar with the area. She stated on 02/14/2026 (R1) forgot to sign out when he left the building. He was later found by local law enforcement walking in the road and returned to the facility. The facility was not aware that (R1) was missing from the building and did not document his safety log check until after he was returned. The administrator stated all residents were supposed to sign out with the time, date, and where they were going when they leave the facility. The administrator stated they were having a Valentine party for the facility residents and didn't realize (R1) was gone until they went to his room to find him at 2:00 PM. When asked if she was aware that the guardian for (R1) requested that he always needed to have someone with him when he left the facility, she stated "yes". The administrator further stated that a negative outcome for a resident to wander off the property would be safety concerns. She stated, "I will put something in (R1's) chart that either a buddy or staff needs to always accompany him when he leaves the facility." This information was placed in the chart of (R1) by the Administrator for the first time on 02/18/2026 at 3:00 PM.	P 210		