STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215128	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtland, LLC	7920 Scotts Level Road Baltimore, MD 21208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Number of residents sampled: Number of residents cited: Based on review of facility investigation, resident medical records, and interviews, it was determined that the facility failed to ensure that a resident remained free from abuse. This was true for 1 (Residents #2) of 16 residents reviewed for abuse during the annual re-certification survey. The findings include:Nursing Practice Act: 10.27.19.02:D. A nurse may not engage in sexual misconduct. Sexual misconduct includes but is not limited to: (3) Solicitation of a sexual relationship, whether consensual or nonconsensual, with a client.On 7/16/2025 at 8:15 AM the facility reported incident (FRI) was reviewed. Staff #37, GNA (Geriatric Nursing Assistant) and Staff #38, RN (Registered Nurse) walked into the room on 10/6/2024 on evening shift and witnessed Staff#39, GNA touching Resident #2 in their vaginal area and kissing Resident #2's breast. Later the Administrator interviewed Staff #39, the GNA accused of the allegations. Staff #39, GNA stated that they cleaned Resident #2, and the Resident asked them to put barrier cream on their virginal area due to itching, which they did. Staff #39 also denied kissing Resident #2's breast. Staff # 39 did admit to giving Resident #2 a kiss on the lips.On 7/16/2025 at 9:29 AM, Resident #2 was interviewed about the October 2024 incident with Staff #39, GNA. Resident #2 stated that they initiated physical contact and consented to everything, specifically asking Staff #39 to apply cream to their vagina. Resident #2 denied Staff #39 kissing her breast but admitted Staff #39 kissed her on the lips.On 7/18/2025 at 8:30 AM, the facility policy was reviewed. The policy states, Employees shall not become romantically or sexually involved with a resident or a co-worker with whom he/she is in a supervisory position. Further record review revealed that Staff #39 was terminated on 10/11/2024 for violating the company's Standard of Conduct Policy.On 7/18/2025 at 10:05 AM the Administrator was asked about the FRI between Resident #2 and Staff #39. The Administrator recalled that Staff #39 was accused of inappropriate touching Resident #2, which Staff #39 denied, but admitted to kissing Resident #2 on the lips.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, it was determined the facility failed to 1) notify the Ombudsman of resident's transfers, 2) provide the Resident and/or Representative with a written notice of the facility's bed hold policy upon transfer. This was found evident of 2 (Resident #10 & #141) of 4 residents reviewed for hospitalization 3. Failed to provide the resident/family/RP with discharge instructions. (#161) This was evident for 1 of 3 discharge records reviewed during the survey. The findings include: 1a) On 7/16/25 at 9:29 AM, the surveyor reviewed Resident #10’s medical record. The review revealed that Resident #10 was sent to the hospital on 4/25/25 and returned to the facility on 5/2/25. On 7/21/25 at 1:18 PM, the surveyor requested documentation to demonstrate that the Ombudsman was made aware of the hospitalization. On 7/21/25 at 1:42 PM, the surveyor conducted an interview with the Regional Clinical Director of Operations Staff #5. During the interview Staff #5 confirmed that during that time period no one at the facility was providing notices to the Ombudsman of transfers and discharges. 1b) On 7/22/25 at 7:03 AM, the surveyor reviewed Resident #141’s medical record. The review revealed that Resident #141 was hospitalized on [DATE]. On 7/22/25 at 7:56 AM, the surveyor requested documentation to demonstrate that the Ombudsman was made aware of the hospitalization. On 7/22/25 at 8:45 AM, the surveyor interviewed the Regional Clinical Director of Operations Staff #5. During the interview Staff #5 confirmed that during that time period no one at the facility was providing notices to the Ombudsman of transfers and discharges. 2a) On 7/16/25 at 9:29 AM, the surveyor reviewed Resident #10’s medical record. The review revealed that Resident #10 was sent to the hospital on 4/25/25 and returned to the facility on 5/2/25. On 7/21/25 at 1:18 PM, the surveyor requested documentation to demonstrate that the Bed Hold policy was given to Resident #10’s Responsible Party (RP). On 7/21/25 at 1:46 PM, the Regional Clinical Director of Operations Staff #5 stated he was unable to find documentation that the written notice was sent to Resident #10’s Responsible Party (RP). 2b) On 7/22/25 at 7:03 AM, the surveyor reviewed Resident #141’s medical record. The review revealed that Resident #141 was hospitalized on [DATE]. On 7/22/25 at 7:56 AM, the surveyor requested documentation to demonstrate that that the Bed hold policy was given to Resident #141’s Responsible Party (RP). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 at 8:45 AM, the surveyor interviewed the Regional Clinical Director of Operations Staff #5. During the interview Staff #5 stated that he found documentation that stated the bed hold policy sent with the Resident to the hospital. Staff #5 was not able to provide evidence that a written notice was given to Resident #141’s RP. Next the survey reviewed the facility’s bed hold policy. The policy states, The resident and his/her surrogate decision-maker or court appointed legal representative will be provide written and/or verbal information regarding the bed-hold policy at the facility: Upon admission, At the time of transfer to the hospital, at the time of any therapeutic leave and if the bed-hold regulation were to change. 3. During the review of Resident #161’s medical record on 7/21/25 at 8:28 AM discharge planning revealed that there was no documentation of what was provided to the family/resident/representative (RP) at the time of discharge regarding planning, preparation and medications. Resident #161 was being discharged from the facility after rehabilitation from deconditioning and medication management after a kidney transplant. On 7/21/25 this surveyor requested any discharge planning and paperwork that was provided to the family/resident at discharge. On 7/22/25 at 6:42 AM the Regional Clinical Director notified this surveyor that there was no discharge paperwork in the record. The concern was reviewed with him at this time that there was no discharge planning and directions provided to the family of a resident with complex diagnosis' including gastrostomy tube feeding, wound care and anti-rejection medications needed for kidney transplant.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on medical record, review of a complaint, and interview of facility staff, it was determined that the facility's Medical Director failed to ensure adequate implementation of resident care intervention and/or policy review. This was found evident for 1 (Resident #98) of 1 resident reviewed for insulin use. The findings include: On 7/16/25 at 12:32 PM, the surveyor interviewed Resident #98. During the interview Resident #98 described that when he/she was admitted to the facility he/she was prescribed a glucose monitoring device that was utilized to monitor blood glucose levels without the use of a finger stick. Resident #98 stated he/she was very happy with the use of the device but shortly after the device was ordered it was discontinued. On 7/23/25 at 11:35 AM, the surveyor reviewed Resident #98's medical record. The review revealed an order was placed for 3/27/24 for Resident 98 to have a continuous glucose monitoring device. On further review, Nurse Practitioner (NP) #42 documented, on 4/6/24 in a progress note, that the patient was seen for a follow-up. Patient and patient's daughter are upset that they cannot use the continuous glucose monitoring and now will need to utilize finger sticks. Resident #98 reports a lot of pain in his/her fingertips. On 7/24/25 at 6:06 AM, the surveyor interviewed the Regional Clinical Director of Operations Staff #5. During the interview the surveyor requested the facility's policy for continuous glucose monitoring devices. Staff #5 stated that the facility did not have a policy for the use of this device because it is typically utilized in home settings where patients can self manage the device. Staff #5 confirmed that Nurse Practitioner (NP) #42 wrote the order for Resident #98 to have the device due to the request of the family and that Resident #98 utilized the device for approximately 2.5 days. Staff #5 stated that the previous Director of Nursing (DON) did not request clinical oversight from the Regional Clinical Staff and the device was removed when it was made known to Regional Clinical Staff it sues. Staff #5 further stated that the Medical Director spoke to the provider and informed her the device could not be utilized in the building. The Surveyor asked Staff #5 for the education that was provided by the Medical Director. Staff #5 confirmed that the education was non-formal and there was no documentation. There was also no documentation that any education was provided to other providers. The surveyor reviewed the concern that the facility still did not have a policy or procedure written in regard to the use or non-use of continuous glucose monitoring devices and that there was no formal education to providers after the Medical Director was aware the device was implanted within the facility without a policy or procedure for use.