STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365493	A. Building B. Wing	03/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Village	6451 Far Hills Avenue Dayton, OH 45459

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review, staff interviews, and policy review, the facility failed to treat a resident with dignity and respect by violating their privacy. This affected one (#249) out of four residents reviewed for resident rights. The facility census was 248. Findings include: Review of the closed medical record for Resident #249 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included viral pneumonia, depression, psoriasis, hypertension, atrial fibrillation, vitamin d deficiency, localized edema, anxiety disorder, and hyperlipidemia. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #249 had moderately impaired cognition. Resident #249 was assessed to require setup assistance for eating, and oral hygiene, substantial/maximal assistance for bathing, dressing, personal hygiene, and bed mobility, and was dependent on staff for toileting. Review of the facility's counseling/education forms for State tested Nursing Assistants (STNA) #12 and #14 dated 01/20/25 revealed they were educated for taking pictures of a resident that was soiled and showing the pictures to other staff at the facility. The form indicated they were advised not to take pictures of residents with their personal phones or share pictures of residents with other staff. Interviews on 03/02/25 from 1:19 P.M. to 1:49 P.M. via telephone with Registered Nurse (RN) Unit Manager (UM) #100 revealed there was an incident where a picture was taken of a resident, and the staff involved were STNAs #12 and #14. RN UM #100 stated the picture did not show the resident's face and only showed their hands and abdominal area that were soiled. RN UM #100 reported she completed a counseling form with both employees involved. Interview on 03/02/25 at 1:45 P.M. with the Director of Nursing (DON) revealed the picture was alleged to be of Resident #249 and showed feces on their hands and abdominal area. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/02/25 at 1:52 P.M. via telephone with STNA #14 revealed she delivered a breakfast tray to Resident #249 and discovered her hands were dirty. STNA #14 stated she informed Resident #249's aide, STNA #12, and both staff pulled back the blankets on Resident #249 where it was revealed the resident was soiled with feces. STNA #14 verified she took a picture of Resident #249's legs that had feces on them and sent the picture to STNA #12 who then shared the picture with RN UM #100. Interview on 03/02/25 at 2:12 P.M. via telephone with STNA #16 revealed STNA #12 showed her the picture and said it was of Resident #249. STNA #16 stated she reported the incident to RN UM #100. Review of the policy titled, Residents' Rights, reviewed 10/22/19, revealed residents had the right to be treated with respect and dignity. This deficiency represents non-compliance investigated under Master Complaint Number OH00161794.