STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335635	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leroy Village Green Residential Health C F, Inc	10 Munson Street Leroy, NY 14482

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review conducted during a survey, the facility failed to ensure a resident had the right to be free from abuse, neglect, misappropriation of resident property for one (Resident #1) of three residents reviewed. Specifically, Resident #1's rings were reported missing. It was determined by local police that on 11/08/2025 at least one of Resident #1's rings were in Certified Nurse Aide #1's possession and a transaction had been made at a pawn shop. The findings include:The facility policy titled Abuse Policy Prevention and Management dated 09/08/2022, documented the facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation. Exploitation of residents /patient's property by anyone including staff, family, friends and visitors. The facility has designed and implemented processes which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment and or misappropriation/exploitation of property. The facility must provide a safe resident environment and protect residents from abuse.Resident #1 had diagnoses including dementia without mood disturbances, anxiety, and depression. The Minimum Data Set (a resident assessment tool) dated 03/24/2026 documented Resident #1 had severe cognitive impairment, was rarely understood, and rarely understands.The Care Plan Activity Report, dated 02/04/2024, documented Resident #1 had a cognitive and communication deficit and was mainly non-verbal.The Progress note written by Registered Nurse Supervisor # 1dated 11/08/2025 documented they were notified that Resident #1 was missing two (2) rings. This writer called the resident's Family Member #1 to inquire if they had taken them home. The resident's room was searched. Resident #1 had a shower yesterday and shower room and shower chair were checked. Family Member #1 stated they would check with the family if anyone took them home. Family Member #1 stated Resident #1 had lost some weight and may have slipped off, but it was doubtful.The facility Complaint Summary completed by the Administrator dated 03/19/2026 documented on 11/08/2025 Family Member #1 reported Resident #1's wedding rings were missing. The facility did a full investigation and filed a police report with the local police department. After interviewing all staff and searching the building the rings were never found. On 3/19/2026 the local police department came to the facility to notify them that one of the rings was found at a pawn shop. The person that pawned the ring was Certified Nurse Aide #1, who was an agency certified nurse aide who had been at the facility when the rings went missing.Review of an untitled unsigned document provided by the facility Administrator on 6/3/2026 at 11:15 AM documented I (Certified Nurse Aide #1) am writing this statement because I was informed by my agency that sometime between (11/7-11/8) while caring for a resident (Resident #1) or while working that unit/facility some rings have come up missing. I did work that unit a number of times since I've been there, I don't know exactly who the resident is. I have no recollection of any jewelry in any time frame from 8 PM Friday 11/7/2025 until 8 AM 11/8/2025.The Supplemental Report dated 03/25/2026, provided by Detective #1 documented on 03/16/2026 that Detective #1 went to local pawn shops to track down the missing rings. At one local pawn shop Detective #1 showed the manager a picture of the missing rings and Certified Nurse Aide #1. The manager of the pawn shop provided Detective #1 a transaction made on 11/08/2025 by Certified Nurse Aide #1. Additionally, the report documented the family of Resident #1 identified the ring as one of the rings that went missing.During an interview on (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/18/2026 at 8:44 AM, the Administrator stated they did not report the rings at the time they went missing to the New York State Department of Health because the facility did not know if the rings were just lost or if they were stolen. The Administrator stated according to the Manual (State Operations Manual- a set of regulatory guidelines issued by the Centers of Medicare and Medicaid Services) the facility did not have to report unless there was a suspicion of a crime. Law enforcement was notified, and a police report was filed. Staff were interviewed back in November, and family was notified. The family did not have possession of the two missing rings. When one of the rings was found and the facility was informed the rings were stolen, the facility reported the incident to the New York State Department of Health.Durning a telephone interview on 05/18/2026 at 2:21 PM, Family Member #1 stated they thought it was a possibility the rings could have fallen off Resident #1 hand because Resident #1 had a little weight loss recently but really didn't think they fell off. They were happy with how the facility conducted the investigation, stating a staff member realized the rings were missing and reported it. One ring was located; the other was still missing.During an interview on 05/18/2026 at 2:31 PM, Registered Nurse Supervisor #1 stated Restorative Aide #1 reported to them that Resident #1 had two (2) rings missing from their finger and that Resident #1 had them yesterday when they provided range of motion. Registered Nurse Supervisor #1 stated they completed an Accident and Incident Report and searched the resident's room and reported the rings missing to administration.During a telephone interview on 05/19/2026 at 9:05 AM, Detective #1 stated one of the rings was found at a pawn shop and returned to Resident #1's family. Additionally, they stated Certified Nurse Aide #1 did not admit to stealing the rings, but the investigation was still ongoingDuring a telephone interview on 05/19/2026 at 3:00 PM, Restorative Aide #1 stated they reported the missing rings to Registered Nurse Supervisor #1 sometime in November but could not recall the exact date. They performed range of motion to Resident #1 hands routinely and that's how they knew the rings were missing. Restorative Aide #1 stated one (1) of the rings were a little loose but did not believe it was loose enough to slide of the resident's finger.During a telephone interview on 06/02/2026 at 2:12 PM, Certified Nurse Aide #1 stated they found the rings along with other jewelry in a box of free things for staff to take in the facility breakroom, took the ring to a pawn shop, and pawned the ring.During an interview on 06/03/2026 at 10:50 AM, the Administrator with the Director of Nursing present stated staff leave items in the breakroom for other staff to take for free, like books, clothing and uniforms. They were unaware if jewelry items were ever left. The facility does not leave items for staff to take.New York Code Rules and Regulations 415.4(b)(1)