STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315142	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION CENTER	**1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ183820, NJ184049 Census: 90 Sample Size: 7 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		

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

Electronically Signed | 05/05/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061611	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION C	1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

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S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 13 day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff	S 560	1. There were no care concerns reported on the 22 shifts that were identified. Ongoing recruiting efforts and agency usage to mitigate short staffing schedules. 2. All residents have the potential to be affected by this deficient practice. The interdisciplinary team reviewed the grievance log and care conference meetings and no care issues were identified. 3. a. Administrator in-serviced the staffing coordinator regarding the ratio requirement for S560 to ensure Certified Nursing Aides staffing needs are reviewed daily and addressed as needed to meet the staffing requirement. b. Recruitment efforts are in place to assist the facility in recruiting proper staff as needed. c. The facility has contracted with agencies to utilize when staffing is short. d. The Director of Nursing / Designee reviews the staff attendance records to ensure that excessive absences are addressed accordingly. e. Staffing coordinator / designee will audit staffing ratios weekly x4, monthly x3 and quarterly thereafter. 4. The Administrator/ Designee will have	5/7/25

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

Electronically Signed | 05/05/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061611	A. BUILDING: _____ B. WING _____	C 04/03/2025

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S 560	Continued From page 1 member shall sign in to work as a CNA and perform CNA duties. For the week of Complaint staffing from 02/02/2025 to 02/15/2025 for the 03/05/2025 Complaint survey, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/02/25 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/03/25 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/04/25 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/05/25 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/06/25 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/07/25 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/08/25 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/09/25 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -02/10/25 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/11/25 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/12/25 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/13/25 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -02/14/25 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. -02/15/25 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.	S 560	weekly meetings with the staffing coordinator to review staffing schedules, needs, and the efficacy of the systems in place to fill needs. The finding of the audit will be presented at the Quarterly Quality Assurance Performance Improvement meeting to determine the future of frequent audits.	

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	061611	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 For the 2 weeks of AAS-11 staffing from 03/09/2025 to 03/22/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -03/09/25 had 6 CNAs for 92 residents on the day shift, required at least 11 CNAs. -03/10/25 had 6 CNAs for 91 residents on the day shift, required at least 11 CNAs. -03/11/25 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs. -03/12/25 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs. -03/15/25 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -03/16/25 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs. -03/17/25 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -03/18/25 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -03/19/25 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -03/20/25 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -03/21/25 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -03/22/25 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of	S1680		5/7/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1680	Continued From page 3 nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

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S1680	Continued From page 4 This REQUIREMENT is not met as evidenced by: For the 2 weeks of AAS-12 staffing from 03/09/2025 to 03/22/2025, the facility was deficient in staffing for resident required services as follows: For the week of 03/09/25 Required Staffing Hours: 247.25 -03/09/25 had 232 actual staffing hours, for a difference of -15.25 hours. -03/10/25 had 232 actual staffing hours, for a difference of -15.25 hours. For the week of 03/16/25 Required Staffing Hours: 245.75 -03/16/25 had 240 actual staffing hours, for a	S1680	1. No residents had a negative impact on the dates noted to be short. The Director of Nursing with the Staffing Coordinator audited the acuity of the building to set the appropriate amount of staffing necessary. 2. This deficient practice has the potential to affect all residents. The interdisciplinary team reviewed the grievance logs and care conference meetings and no care issues were identified during the dates noted shorts. 3. a. The Director of Nursing audited the acuity of the current residents to staffing continued adequately. b. The Director of Nursing in-serviced the staffing coordinator on calculating acuity hours for the nursing staff. c. The Director of Nursing in-serviced the staffing coordinator on hours necessary	

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S1680	Continued From page 5 difference of -5.75 hours. -03/17/25 had 240 actual staffing hours, for a difference of -5.75 hours	S1680	based on acuity. d. The Director of Nursing / designee will audit staffing based on acuity hours weekly 4, monthly x3, and quarterly thereafter. e. The facility has signed contracts with staffing agencies to use when short staffed. f. The facility has ongoing recruitment efforts to hire new staff as needed. 4. The Director of Nursing / designee will bring results of this audit to the Quality Assurance Performance Improvement team, to determine the future frequency of these audits.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061611		5/14/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION CENTER	1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/07/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 05/07/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/3/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: MSPB12

STATE FORM: REVISIT REPORT (11/06)