

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315520	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER SOMERSET WOODS REHABILITATION & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 780 OLD NEW BRUNSWICK ROAD , SOMERSET, New Jersey, 08873	
(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
F0000	<p>INITIAL COMMENTS</p> <p>The NJDOH conducted a complaint survey on 10/7/25. The survey was officially completed on 10/7/2025.</p> <p>Complaint #: 2630765</p> <p>Census: 111</p> <p>Sample Size: 3</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.</p>	F0000		11/19/2025

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 reverse for further 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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New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER SOMERSET WOODS REHABILITATION & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 780 OLD NEW BRUNSWICK ROAD , SOMERSET, New Jersey, 08873	
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S0000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S0000		11/28/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 2630765 Based on review of facility documents on, it was determined that the facility failed to ensure staffing ratios were met for 2 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: 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	S0560	1) No residents were identified on the 2567 as having been affected by the deficient practice. 2) This deficient practice has the potential to affect all residents. 3) Staffing Coordinator was educated by the Administrator regarding the Mandatory Staffing Ratios and instructed to update the contact information of all current licensed personnel, so staff can be called in to meet staffing needs in case of call-outs. 4) Staffing ratios will be monitored daily by Administrator or designee for thirty days to ensure compliance. Administrator will audit staffing reports monthly for three months. Results will be reported quarterly to the QAPI meeting for two quarters.	11/28/2025

Office of Primary Care and Health Systems Management

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S0560	<p>Continued from page 1 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 member shall sign in to work as a CNA and perform CNA duties.</p> <p>For the week of Complaint staffing from 09/21/2025 to 10/04/2025, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows:</p> <p>-09/26/25 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs.</p> <p>-10/03/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs.</p>	S0560		

