

KIM REYNOLDS
GOVERNOR
ADAM GREGG
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

September 28, 2018

Mr. David Shields, Clinical Director
Community Neuro Rehab – Ashworth
5008 Ashworth Road
West Des Moines, IA 50266

Dear Mr. Shields,

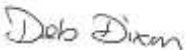
A survey was conducted at your facility by Stephanie Dodge from September 4-5, 2018 to determine if the facility remains in substantial compliance with licensure requirements for a Residential Care Facility, 3-5 Bed Specialized License.

Your facility is in substantial compliance. You and your staff are commended for your efforts.

State laws require public disclosure of survey findings. Documents pertaining to this survey will be available to the public for review at the Department of Inspections and Appeals and the nearest county office of the Iowa Department of Human Services.

We wish to thank you and your staff for the courtesies and cooperation extended to our survey staff during this visit. If you have any questions, please contact us.

Sincerely,
Linda Kellen, Bureau Chief
Special Services Bureau



Deb Dixon, Program Coordinator
Health Facilities Division
(515) 281-4081
Email deb.dixon@dia.iowa.gov

Enclosure: Statement of Deficiencies

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 770049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2018
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER COMMUNITY NEUROREHAB - ASHWORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5008 ASHWORTH ROAD WEST DES MOINES, IA 50266
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------

(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) COMPLETE DATE
T 000	<p>Initial Comments</p> <p>No deficiencies were cited during the survey conducted to determine licensing rules for a Residential Care Facility - three to five bed specialized license.</p>	T 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
------------------------------------------------------------------------------------------------------------------------	-------	-----------