IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
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(515) 281-4115 Phone
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KIM REYNOLDS
GOVERNOR
ADAM GREGG
LT. GOVERNOR

LARRY JOHNSON, JR., DIRECTOR

May 13, 2019

Ashley Black, Administrator
CNR – Auburn Hills
2105 Oakdale Court
Coralville, IA 52241

Dear Ms. Black:

An initial survey was conducted at your facility by Stephanie Dodge on 4/30/19 to determine if the facility is in substantial compliance with licensure requirements for a Residential Care Facility, Three to Five 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

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	526113	A. BUILDING: _____ B. WING _____	04/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NEUROREHAB OF IOWA-AUBUR	**2105 OAKDALE COURT CORALVILLE, IA 52241**

(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	Initial Comments No deficiencies were cited during the initial survey to determine compliance with licensing rules for a Residential Care Facility, Three to Five Bed Specialized License.	T 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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