

KIM REYNOLDS
GOVERNOR
ADAM GREGG
LT. GOVERNOR

LARRY JOHNSON, JR., DIRECTOR

June 26, 2019

Chelsea Adams, Administrator
Community NeuroRehab-Oneida Point
3000 SW 37th Street
Des Moines, Iowa 50321

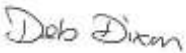
A survey was conducted at your facility by Mike Rohner from 6/18/19 to 6/20/19 to determine if the facility remains in substantial compliance with licensure requirements for an RCF 3 to 5 bed specialized license.

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: 771045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2019
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NEUROREHAB - ONEIDA POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 3000 SW 37TH STREET DES MOINES, IA 50321
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(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 compliance with licensing rules for an RCF 3 to 5 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
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