IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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

LARRY JOHNSON, JR., DIRECTOR

December 17, 2019

Kelly Bumpus, Administrator
Community NeuroRehab – Glen Oaks
2033 Glen Oaks Ridge
Coralville, IA 52241

RE: AMENDED letter regarding survey

Dear Ms. Bumpus:

A survey was conducted at your facility by Stephanie Dodge on 8/28/19 to determine if the facility remains in substantial compliance with licensure requirements for a 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

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
	522690	A. BUILDING: _____ B. WING _____	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NEUROREHAB - GLEN OAKS	**2033 GLEN OAKS RIDGE 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 There were no deficiencies cited during the survey conducted to determine compliance with rules for a 3 to 5 bed specialized license. This is an AMENDED Statement of Deficiencies.	T 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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