

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 526113	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/22/2021
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NEUROREHAB OF IOWA-AUBUR	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 OAKDALE COURT CORALVILLE, IA 52241
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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>There were no deficiencies cited during the onsite infection control survey, the investigation of Complaint #93981-C or the survey conducted to determine compliance with licensing rules for a 3-5 bed Specialized License Residential Care Facility.</p>	T 000		

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