

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>855808</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY NEUROREHAB OF IOWA - TIMBE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2415 TIMBERLAND ROAD AMES, IA 50014</b>
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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 initial survey conducted to determine compliance with licensing rules for a 3-5 Bed Specialized Licensed 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 \_\_\_\_\_