



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, MN 55427
Hennepin County

Report #: H5186150

Date: November 25, 2008

By: Pat FitzGibbon, R.N.

Nature of Visit:

A desk investigation was initiated on November 3, 2008, related to the following complaint:

A resident arrived at his dialysis appointment on 9/22/08, with no pants on and only a sheet covering him. In addition, twice the resident arrived at dialysis with his oxygen tank empty, once on 9/17, and again on 9/19.

Conclusion:

Substantiated that the resident was inadequately dressed when he was sent to dialysis appointment on September 22, 2008. However, evidence was inconclusive regarding the resident being sent to dialysis with an empty oxygen tank on September 17, 2008 and September 19, 2008. However, the facility has taken corrective action and, as a result, no violations will be issued.

xc: Division of Compliance Monitoring - Licensing & Certification

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2008
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NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427
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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) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An Administrative review was conducted to investigate H5186150. No violations were noted.</p>	F 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.