



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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February 14, 2011

Sandee Young, Administrator  
Stefney Layton  
821 Wildrose Ln  
Blackfoot, ID 83221

Dear Ms. Young:

An unannounced, on-site complaint investigation survey was conducted at Lighthouse Living LLC from January 27, 2011, to January 27, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004877

Allegation # 1: An identified resident did not receive a 30 day written notice.

Findings #1: Substantiated. However, the facility was not cited as they had rescinded the 30 day notice. The facility worked with the resident and the resident's court appointed guardian to correct the problems identified, so the resident would not have to move out of the facility.

Allegation #2: The facility did not respond immediately to an identified diabetic resident when their blood glucose level was low.

Findings #2: On 1/27/11 the identified resident's record was reviewed. Medication Assistances Records (MAR) for November, December and January were reviewed. There was no documentation that the resident experienced low blood glucose levels in November or December. The January MAR documented the resident had three episodes of low blood glucose levels. There was no documentation of the interventions that staff took to assist the resident with her low blood glucose levels. Additionally, there was no documentation in the resident's care notes regarding the low blood glucose levels or staff's response.

On 1/27/11 at 2:15 PM, the identified resident was interviewed. She stated when her blood glucose levels were low staff would give her juice or something to eat, then recheck her blood later. She stated staff responded quickly and appropriately when her glucose levels were low.

On 1/27/11 at 2:30 PM, a staff member stated the nurse had instructed them on how to respond when a diabetic resident had low blood glucose levels. She stated when a resident had a glucose level below 70 they were to provide the resident with juice or a snack, recheck the level in 15 minutes and then notify the nurse.

Unsubstantiated. This does not mean the incident did not take place; it only means that the

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allegation could not be proven. However, the facility received a deficiency at IDAPA 16.03.22.711.08.c for not documenting the response to a resident's low blood glucose levels.

Allegation #3: Residents were not paid to help take care of an employee's child.

Findings #3: On 1/27/11 between 2:00 PM and 4:30 PM, five residents were interviewed. All five residents stated they did not take care of an employee's child. All five mentioned the baby would come to the facility and they would hold the baby. They further stated they enjoyed having the baby in their home.

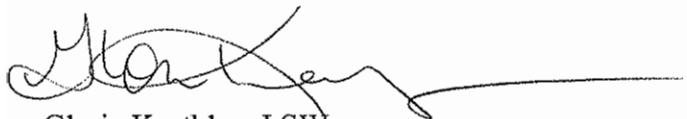
Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: Water temperature in an identified resident's room was above 120 degrees.

Findings #4: Substantiated. However, the facility was not cited as Fire and Life Safety surveyors had cited the facility for hot water temperatures being above the maximum allowed on 1/13/2011. The facility was working to reduce the temperature of the hot water.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Gloria Keathley, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

cc: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program

