



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 98907, Lakewood, WA 98496

September 27, 2016

Ariyo A Oyetuga
Funmilayo I Oyetuga
KARE HOME
7506 95TH AVE SW
LAKEWOOD, WA 98498

RE: KARE HOME License #528500

Dear Provider:

On September 26, 2016 the Department completed a review of communication and / or documents from you indicating that you have corrected the deficiency or deficiencies cited in the report/s dated July 20, 2016.

Based on the review of this information the Department finds the deficiency or deficiencies have been corrected. Your home meets the adult family home licensing requirements.

The Department staff who did the off-site verification:
Barbara Leiter-Arnold, Complaint Investigator

If you have any questions please, contact me at (253) 983-3826.

Sincerely,

Lisa Cramer, Field Manager
Region 3, Unit A
Residential Care Services



**Residential Care Services
Investigation Summary Report**

Provider/Facility: KARE HOME (687114)

Intake ID(s): 3246200

License/Cert. #: AF528500

Investigator: Arnold, Barbara

Region/Unit: RCS Region 3/Unit A

Investigation Date(s): 07/15/2016 through 07/20/2016

Complainant Contact Date(s): 07/19/2016

Allegations:

Named resident aimed a gun at [REDACTED] and refused to put the gun down.

Investigation Methods:

Sample: 3 of 3 sampled residents including named resident

Observations: Interaction of staff with residents
General observations of unit environment

Interviews: Staff
Residents
Case manager
VA nurse

Record Reviews: Resident record

Allegation Summary:

The named resident did have a gun and did point the gun at [REDACTED]. An inventory of the named resident's belongings was completed within 24 hours of admission to the adult family home. The assessment did not identify any mental health issues nor was the provider advised of any issues the named resident may have had with depression. The gun was first seen when a collateral contact was assisting the resident set up his/her computer. The gun was hidden in the computer tower. It was believed the named resident later moved the gun. On the day of the incident the named resident pulled the gun and threatened to shoot [REDACTED]. The police were called, the gun was seized and named resident was taken to the hospital. The provider did not remove the gun at the time it was observed in the computer tower.

Unalleged Violation(s): Yes No

None

Conclusion / Action: **Failed Provider Practice Identified / Citation(s) Written**

Failed Provider Practice Not Identified / No Citation Written

The investigator conducted on on-site investigation on the above dates related to all allegations and/or incidents identified in the



**Residential Care Services
Investigation Summary Report**

intake. Facility practice was found on the original allegations. See Statement of Deficiency dated 07/20/2016, cited WAC 388-76-10400(3)(b) Care and Services.



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Statement of Deficiencies	License #: 528500	Completion Date
Plan of Correction	KARE HOME	July 20, 2016
Page 1 of 3	Licensee: FUNMILAYO	AMENDED

You are required to be in compliance with all of the licensing laws and regulations at all times to maintain your adult family home license.

The department has completed data collection for the unannounced on-site complaint investigation of: 7/15/2016 and 7/19/2016

KARE HOME
 7506 95TH AVE SW
 LAKEWOOD, WA 98498

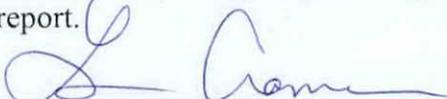
This document references the following complaint number: 3246200

The department staff that inspected and investigated the adult family home:
 Barbara Leiter-Arnold, RN, Complaint Investigator

RECEIVED
 AUG 09 2016
 DSHS RCS Region 3

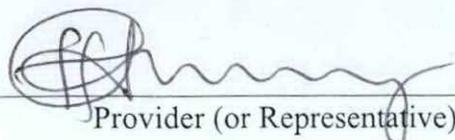
From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 3, Unit A
 PO Box 98907
 Lakewood, WA 98496
 (253)983-3826

As a result of the on-site complaint investigation the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.


 Residential Care Services

7/25/16
 Date

I understand that to maintain an adult family home license I must be in compliance with all the licensing laws and regulations at all times.


 Provider (or Representative)

8/5/16
 Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

- (3) The care and services in a manner and in an environment that:
- (b) Actively supports the safety of each resident; and

This requirement was not met as evidenced by:

Based on interview and record review, the provider failed to provide a safety environment for 5 of 5 residents (Resident #1, #2, #3, #4 and #5) after a gun was found in the home. This failure placed the resident at risk for potential harm. Findings include:

Resident #1 was admitted to the facility on [REDACTED] 2016 from [REDACTED] private home with diagnoses of [REDACTED] and other diagnoses as listed in record.

Resident #1 arrived at the home in the late afternoon of [REDACTED] 2016. Personal inventory of belongings was started the next day on [REDACTED] 2016 and after several hours it was decided to complete the inventory on another day. The only items not inventoried at that time were a drawer of Resident #1's dresser.

Resident #1 frequently left the home and put off the request to complete the inventory of his/her belongings.

Resident #1 had problems with getting his/her computer to work. On 07/11/16 the provider requested the collateral contact (her husband) assist with the process of getting the computer to work since the collateral contact had skills in computers.

While assisting with this process, the back of the computer tower was removed. Collateral contact saw an item wrapped in a washcloth which he believed was a gun. Collateral contact replaced the back on the computer tower and left the room to discuss the sighting with the owner. The potential gun was not removed.

On 07/11/16, the provider contacted Resident #1's case manager for guidance in this situation. The case manager instructed the provider to call the police and have the gun removed. The provider went into Resident #1's room and with [REDACTED] permission, removed the back of the computer tower. The provider said she did not ask Resident #1 about the gun and did not call the police since she said she had no knowledge of where the gun was located.

The case manager visited Resident #1 on 07/13/16. Again the case manager had a conversation with the provider concerning the gun since the provider had taken no action on removing the gun from the resident's possession.

Provider stated the nurse from the VA was coming tomorrow (07/14/16) and they would look for the gun.

On 07/13/16 at 4:24 PM, a voice message was left with the home's licenser. The licenser returned the call on the morning of 07/14/16 and asked what the home's policy was regarding residents having a firearm (gun) in the home. If allowed, the licenser stated the gun must be in locked storage and noted on the resident's personal belongings inventory.

On 07/14/16 the nurse from the VA came to visit Resident #1. The nurse was trying to assist Resident #1 with the

transition from [redacted] apartment to the home. Resident #1 became upset after discussing finances. The VA nurse, interviewed on 07/20/16 stated she specifically asked Resident #1 if [redacted] had a gun. Resident #1 stated "no". Resident #1 was asked if [redacted] planned to hurt [redacted] today or in the next week and [redacted] answered "no". Resident #1 was asked if (s)he would talk to a counselor and the resident stated "no". The VA nurse left the home.

The provider encouraged Resident #1 to allow her to finish the inventory. While the provider was completing the inventory, Resident #1 pulled the gun from the top dresser drawer and aimed the gun at [redacted] and stated she (provider) would have to live with seeing [redacted] kill [redacted]. The provider called 911.

Resident #1's roommate was not in the room at the time of the incident. Staff B encouraged the residents to stay in their rooms. When the police arrived at the house, they evacuated the residents from the house. After a period of time, Resident #1 was taken to the hospital and the police seized the gun.

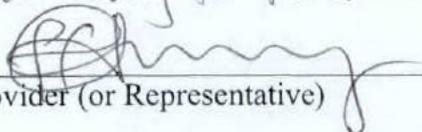
Resident #2 was interviewed on 07/18/2016 who stated [redacted] did not have any interaction with the resident. [redacted] stated [redacted] was not afraid of the resident or the situation and felt safe living in the home.

The provider placed Resident #1, the other residents and staff of the home at risk due to the delay with removing the gun from the home once the gun was observed in the computer tower on 07/11/16.

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, KARE HOME is or will be in compliance with this law and / or regulation on (Date) 7/18/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Kare Home Admission Contract has been updated according to Firearms policy & Residents rights.



 Provider (or Representative)

8/5/16

 Date