



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Cynthia Ubah
Longer Life LLC
4625 Julius Blvd
Westland, MI 48186

RE: License #: AS820414226
Investigation #: 2025A0101030
Perfect Care Home

Dear Ms. Ubah:

Attached is the Special Investigation Report for the above-referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone

immediately, please contact the local office at (313) 456-0439.

Sincerely,

A handwritten signature in blue ink, appearing to read "Edith Richardson".

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AS820414226
Investigation #:	2025A0101030
Complaint Receipt Date:	06/26/2025
Investigation Initiation Date:	07/03/2025
Report Due Date:	08/25/2025
Licensee Name:	Longer Life LLC
Licensee Address:	4625 Julius Blvd Westland, MI 48186
Licensee Telephone #:	(734) 881-2688
Administrator:	Cynthia Ubah
Licensee Designee:	Cynthia Ubah, Designee
Name of Facility:	Perfect Care Home
Facility Address:	4625 Julius Blvd Westland, MI 48186
Facility Telephone #:	(734) 709-5880
Original Issuance Date:	05/25/2023
License Status:	REGULAR
Effective Date:	11/25/2024
Expiration Date:	11/24/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has a bruise on her left arm because the licensee designee Cynthia Ubah punched her in the arm multiple times in the same spot over the weekend (05/24/2025 and 05/25/2025).	No

III. METHODOLOGY

06/26/2025	Special Investigation Intake 2025A0101030
06/26/2025	APS Referral Received from APS
07/03/2025	Special Investigation Initiated - Telephone APS worker Deante Brown
07/08/2025	Contact - Telephone call made Mr. Brown
07/10/2025	Contact - Telephone call made Mr. Brown
07/10/2025	Contact - Document Sent e-mail Mr. Brown
07/15/2025	Contact - Telephone call made Mr. Brown
07/15/2025	Contact - Telephone call made Guardian A1
	Contact – Document received Guardian A1 photo
07/15/2025	Contact - Telephone call made Nurse Susan Mullen
07/15/2025	Contact – Document received Ms. Mullen photo
07/15/2025	Contact - Telephone call made Resident A's current placement

07/15/2025	Contact - Telephone call made licensee designee, Cynthia Ubah
07/15/2025	Contact – Document received from Ms. Ubah Resident care agreement Assessment plan Treatment plan
07/16/2025	Inspection Completed On-site Resident A's current placement, The Journey Home
07/17/2025	Contact - Telephone call made Resident A
07/18/2025	Inspection Completed On-site Interviewed Licensee designee Cynthia Ubah Direct care staff Sister Sancus Osuokata Reviewed Resident A's file
07/21/2025	Contact - Telephone call made Resident A's caseworker Ashley Dewberry, Team Wellness
08/26/2025	Exit Conference with Ms. Ubah

ALLEGATION: Resident A has a bruise on her left arm because the licensee designee, Cynthia Ubah, punched her in the arm multiple times in the same spot over the weekend (05/24/2025 and 05/25/2025).

INVESTIGATION: On 07/15/2025, I spoke with Guardian A1. Guardian A1 stated she observed the bruise on Resident A's left arm. Guardian A1 stated she has a photo of the bruise and would forward a copy to me. Guardian A1 stated Resident A does not have a history of making false allegations.

On 07/15/2025, I spoke with nurse Susan Mullen. Ms. Mullen stated Resident A has a nurse because Resident A was hit by a car. Ms. Mullen stated Resident A has a traumatic brain injury. Ms. Mullen stated she transports and attends all of Resident A's medical and psychiatric appointments. Ms. Mullen stated when she picked Resident A up for an appointment on 05/27/2025, Resident A showed her the bruise. Ms. Mullen stated she took a photo of the bruise, and she agreed to forward it to me. Ms. Mullen stated Resident A does not have a history of making false allegations.

On 07/15/2025, I reviewed the photo from Guardian A1 and Ms. Mullen. They appear to be taken at the same location because the backgrounds are the same. The bruise does not appear to be from a punch. The bruise appears to be from a hand palm and fingers. The bruise could have been from someone's right open hand hitting the same spot multiple times on the left arm or someone squeezing the arm for an extended period of time. The bruise also appeared to be healing because it had some yellow discoloration.

On 07/15/2025, I reviewed Resident A's assessment plan, dated 01/06/2024. According to Resident A's assessment plan, Resident A requires assistance with bathing.

On 07/17/2025, I spoke with Resident A. Resident A stated her room was not clean and Sister wanted her to clean her room. Resident A stated she did not want to clean her room. Resident A stated that Sister was yelling at her in the Sister's "African" language. Resident A stated she started to argue with Sister because she had the right to defend herself. Resident A stated that when Cynthia arrived at the home, that weekend Sister told her about the argument. Resident A stated Cynthia got mad and hit her on the arm.

On 07/18/2025, I interviewed direct care staff Sancus Osuokata (AKA Sister). The residents call Ms. Osuokata, Sister, because she is a nun. Sister stated she has been physically abused by Resident A on many occasions, and she has never retaliated. Sister was so upset that she stated she was going to quit. Sister stated that she assisted Resident A with bathing the night before she left with Ms. Mullen. Sister stated she did not observe any bruises on Resident A. Sister further stated she did not see a bruise on Resident A's arm the next morning when she left with Ms. Mullen because she was wearing a jacket. Sister also stated Ms. Ubah does not come to the home on the weekends.

On 07/18/2025, I interviewed the licensee designee Cynthia Ubah. Ms. Ubah denied the allegation that she hit Resident A. Ms. Ubah stated she does not come to the home on the weekends. Ms. Ubah further stated that she had a medical procedure performed earlier that week and she spent the weekend in bed recuperating. Ms. Ubah stated Resident A did not want to be in the home and this was her way to get a new placement. Ms. Ubah stated this was not the first time Resident A alleged, "I hit her." Ms. Ubah stated the last time Resident A alleged, "I hit her," it was reported to Ms. Mullen and the police. According to Ms. Ubah at that time Ms. Mullen told the police Resident A lies when she does not get her way. Ms. Ubah further stated that the first time Resident A alleged that she hit her the police did not observe any bruising on Resident A and returned her to the group home.

On 07/18/2025, I reviewed Resident A's resident record. In the file I saw a letter that stated Resident A was upset because it had been eight months and they still had not found a new placement for her. I also observed an incident report dated 04/17/2025. The incident report stated that Resident A had eloped. The incident report stated

that a police officer found Resident A and he was taking her back to the group home. The incident report stated that Resident A told the police officer that she eloped because Cynthia hit her. The incident report stated the police officer contacted Ms. Mullen. According to the incident report Ms. Mullen told the police officer to return Resident A to the group home because “[Resident A] lies when she does not get her way.” The incident report also stated Resident A was going to visit a man.

On 07/18/2025, I interviewed Resident B. Resident B stated, “I’m physically disabled but otherwise I’m in good health and of sound mind.” Resident B stated that he felt sorry for Resident A. Resident B stated Resident A is “messed up”. Resident B stated Resident A was so “mean and angry”. Resident B stated Sister and Cynthia are so kind to us and she would curse them out, hit them and would throw chairs at them for no reason. I asked Resident B if he saw a bruise on Resident A’s left arm. Resident B responded, “No but if there was a bruise, she probably did it herself.” Resident B further stated Cynthia is not at the group home on the weekends.

On 07/21/2025, I spoke with Resident A’s caseworker Ashley Dewberry. Ms. Dewberry stated Resident A’s behaviors are cursing people out, anger issues, lying and she doesn’t believe she has mental health issues.

On 08/26/2025, I conducted an interview with the licensee designee Cynthia Ubah. Ms. Ubah agreed with my findings.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:

Based upon the preponderance of evidence there are too many inconsistencies in the findings and there is no evidence to determine that Ms. Ubah failed to protect Resident A at all times.

The allegation allegedly occurred on the weekend. According to Ms. Ubah, Sister and Resident B, Ms. Ubah does not come to the group home on the weekends.

According to the complainant, Ms. Ubah ran up and hit Resident A multiple times in the same spot. Running up on someone and hitting them multiple times in the same spot would require holding that person down to ensure that you hit the same spot.

The photos of the bruise appear to be consistent with someone squeezing the arm for an extended period of time and is not consistent with a punch or being hit.

Sister stated the night before Resident A left with Ms. Mullen, she assisted Resident A with bathing and Resident A did not have a bruise. Sister stated when Resident A left with Ms. Mullen, she did not see a bruise because Resident A was wearing a jacket.

Ms. Ubah denied the allegation that she hit Resident A.

Resident B stated if Resident A had a bruise, it was probably self-inflicted.

Resident A's file contained a letter indicating that Resident A was angry because she requested a new placement eight months ago and a new location still had not been found.

According to an incident report in Resident A's file on 04/17/2025, Resident A eloped. Resident A told the police officer she eloped because Ms. Ubah hit her. The police contacted Ms. Mullen. Ms. Mullen told the police officer to return Resident A to the group home because Resident A will lie if she does not get her way.

Ms. Ubah stated that that first time Resident A alleged that she hit her the police officer did not observe any bruising on Resident A and the police officer returned her to the group home.

CONCLUSION:	VIOLATION NOT ESTABLISHED
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ADDITIONAL FINDINGS:

INVESTIGATION: The licensee designee Cynthia Ubah did not update Resident A's assessment plan annually. On 07/15/2025, I reviewed Resident A's assessment plan. The assessment plan was dated 01/06/2024.

On 07/18/2025, I reviewed Resident A's resident record. The only assessment plan I observed in Resident A's resident record was dated 01/06/2025.

On 08/26/2025, I conducted an exit conference with Ms. Ubah agreed with my finding.

APPLICABLE RULE	
400. 14301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The licensee designee Cynthia Ubah did not update Resident A's assessment plan annually. On 07/18/2025, I reviewed Resident A's resident record. The only assessment plan in Resident A's resident record was dated 01/06/2025. Ms. Ubah agreed with my findings.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



Edith Richardson
Licensing Consultant

09/30/2025
Date

Approved By:



09/30/2025

Ardra Hunter
Area Manager

Date