GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 7, 2026

Olatunbosun Ajenifujah
Uttermost Care Inc
25256 Keeler
Redford, MI 48239

RE: License #: AS820420183
Investigation #: 2026A0121027
Keeler St. Home

Dear Mr. Ajenifujah:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On September 23, 2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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) 456-0380.

Sincerely,

K. Robinson

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820420183
Investigation #:	2026A0121027
Complaint Receipt Date:	08/20/2026
Investigation Initiation Date:	08/21/2026
Report Due Date:	10/19/2026
Licensee Name:	Uttermost Care Inc
Licensee Address:	25256 Keeler, Redford, MI 48239
Licensee Telephone #:	(313) 736-6824
Administrator:	Olatunbosun Ajenifujah
Licensee Designee:	Olatunbosun Ajenifujah
Name of Facility:	Keeler St. Home
Facility Address:	25256 Keeler, Redford, MI 48239
Facility Telephone #:	(313) 740-7083
Original Issuance Date:	04/16/2026
License **Status:**	REGULAR
Effective Date:	04/16/2026
Expiration Date:	10/15/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
There is concern that Resident A may be getting his Benadryl and Ibuprofen everyday instead of as needed.	Yes
There is concern that staff is giving Resident A the wrong medication due to the medication logbook not being signed. The medication logbook was not signed for Resident A, and it is unknown what medication was given.	No

III. METHODOLOGY

08/20/2026	Special Investigation Intake 2026A0121027
08/20/2026	Adult Protective Service (APS) Referral Laniesha Steen
08/20/2026	Referral - Recipient Rights
08/21/2026	Special Investigation Initiated - Telephone Call to Ms. Steen with APS
08/24/2026	Contact - Document Sent Email to Ms. Steen
08/25/2026	Inspection Completed On-site Interviewed Resident A and B, licensee designee, Olatunbosun Ajenifujh (“Ola”), direct care staff (DCS), Loveline Onwenu and Sarah Ignofose, home manager, Julia Mbakwem.
09/17/2026	Contact - Telephone call made Ola Ajenifujh
09/18/2026	Contact - Telephone call received Ola Ajenifujh
09/18/2026	Contact - Telephone call made Ms. Steen
09/18/2026	Contact – Telephone call made Guardian A1

09/18/2026	Contact - Document Sent Email to April Dudley with Recipient Rights
09/18/2026	Contact - Telephone call received April Dudley
09/18/2026	Contact - Telephone call made DCS Anne Anuforo
09/21/2026	Contact - Telephone call made Left message for DCS Ndubuisi Ezenwa
09/23/2026	Inspection Completed-BCAL Sub. Compliance Interviewed Ola Ajenifujh.
09/23/2026	Exit Conference Ola Ajenifujh
09/23/2026	Corrective Action Plan Received/Approved

ALLEGATION: There is concern that Resident A may be getting his Benadryl and Ibuprofen everyday instead of as needed.

INVESTIGATION: On 8/25/26 and 9/23/26, I conducted unannounced onsite inspections at the facility. On 8/25/26, I held a brief interview with Resident A who can only say small words or phrases. I asked Resident A if he received his morning medication on 8/25/26 and Resident A replied, “I did.” Resident B reported that he gets all medication as prescribed. Licensee designee, Olatunbosun goes by the name Ola. Ola was present on both inspection dates. Ola acknowledged that his staff were indeed administering Resident A’s PRN (take as needed) on a daily basis, but he stated that he has since in-serviced the whole team on how to administer on-demand medication. I reviewed the staff training log to verify the training was completed by staff on 7/31/26. Per Ola, all staff are fully trained in Medication Administration.

On 9/18/26, I interviewed Guardian A1 by phone. Guardian A1 expressed concern about staff administering Resident A’s Motrin and liquid Benadryl daily versus as need like prescribed. According to Guardian A1, “They were giving him his PRN

medications as regular meds." Guardian A1 reported Resident A's cognitive impairment limits his vocabulary and ability to communicate his needs to staff.

On 9/18/26, I also interviewed direct care staff, Anne Anuforo by phone. Anne admitted that prior to the training on 7/31/26, she had given Resident A all available medications daily, including the PRNs because "they were there with the others."

On 9/18/26, I conferenced the case with investigators, Laneisha Steen with APS and April Dudley with the Office of Recipient Rights. Ms. Steen reported that she did not substantiate and Ms. Dudley did substantiate for overmedicating Resident A.

On 9/23/26, I conducted an exit conference with Ola. Ola stated that he trained the staff to monitor Resident A for unusual behaviors and physical symptoms like fever or runny nose to help determine when he requires PRN medication. Ola said he also created a PRN Medication Record for staff to document and keep record of all PRN medication that is passed, including the reason why it was required. I also recommended that Ola consult with Resident A's physician to learn what cues to look for when determining if PRN medication is needed especially considering the resident cannot communicate those needs.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Licensee designee, Olatunbosun Ajenifujh and direct care staff, Anne Anuforo acknowledged that staff were administering Resident A's PRN medications on a daily basis and not as needed. Therefore, Resident A's medication was not given, taken, or applied as prescribed prior to 7/31/26.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There is concern that staff is giving Resident A the wrong medication due to the medication logbook not being signed. The medication logbook was not signed for Resident A, and it is unknown what medication was given.

INVESTIGATION: On 9/18/26, I interviewed direct care staff, Loveline Onwenu, Sarah Ighofose, and home manager, Julia Mbakwem. Both Loveline and Sarah said they do sign Resident A's Medication Administration Records (MAR) as required. However, Julia indicated that DCS Ndubuisi forgot to sign the MAR once, but the

incident was isolated. Julia reported that she checks the MARs at least one time weekly, noting significant improvement with the medication records.

On 9/18/26, I tried to contact Ndubuisi by phone, but to date, he has not returned my call. Ola indicated that Ndubuisi may not likely return my call due to facing legal issues.

Resident A's date of placement is 7/10/26, so I reviewed his MARs for July and August. Ola explained that he switched from using handwritten medication records at the time of placement to using pharmacy-supplied medication records to reduce documentation errors.

Resident B confirmed that staff sign the medication book "after they do meds",

On 9/23/26, I completed an exit conference with Ola. Ola insisted that all staff sign the medication logs as required. Ola verified the incident involving Ndubuisi's missed signature in July was isolated and corrected the same day.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	On 8/25/26, I observed medication administration records that do contain the signature of the person(s) administering resident medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.



10/06/26

Kara Robinson — Date
Licensing Consultant

Approved By:



10/07/26

Ardra Hunter — Date
Area Manager