



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

October 14, 2025

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

RE: License #: AS820414226  
Investigation #: 2025A0101040  
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**

<b>License #:</b>	AS820414226
<b>Investigation #:</b>	2025A0101040
<b>Complaint Receipt Date:</b>	09/17/2025
<b>Investigation Initiation Date:</b>	09/26/2025
<b>Report Due Date:</b>	11/16/2025
<b>Licensee Name:</b>	Longer Life LLC
<b>Licensee Address:</b>	4625 Julius Blvd Westland, MI 48186
<b>Licensee Telephone #:</b>	(734) 881-2688
<b>Administrator:</b>	Cynthia Ubah
<b>Licensee Designee:</b>	Cynthia Ubah
<b>Name of Facility:</b>	Perfect Care Home
<b>Facility Address:</b>	4625 Julius Blvd Westland, MI 48186
<b>Facility Telephone #:</b>	(734) 709-5880
<b>Original Issuance Date:</b>	05/25/2023
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/25/2024
<b>Expiration Date:</b>	11/24/2026
<b>Capacity:</b>	4
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A's lisinopril and glipizide medications had a hold instruction, and the dates these medications were withheld were not consistent with the information recorded on the blood pressure and blood sugar reading log.	No
Resident A's medication logs and the pills counted were inconsistent. The medications log indicated that Resident A received his medications, however, the medication bottles were full.	No
Resident A's medication logs were incomplete.	Yes
<b>ADDITIONAL FINDINGS</b>	Yes

**III. METHODOLOGY**

09/17/2025	Special Investigation Intake 2025A0101040
09/26/2025	Special Investigation Initiated - On Site Interviewed Resident A Reviewed Resident A's Medication and September medication log Interviewed the licensee designee Cynthia Ubah Reviewed August original medication log and a revised August medication log. Interviewed the Veteran Administration (VA) medical foster home program coordinator Melissa Laird
10/08/2025	Contact – Telephone call made VA medical foster home nurse Danielle King
10/08/2025	Contact – Telephone call made Ms. Laird
10/10/2025	Contact- Telephone call made Ms. Ubah
10/10/2025	Contact- Telephone call made Ms. Ubah

10/10/2025	Contact – Telephone call made Ms. King
10/10/2025	Contact – Telephone call made Ms. Laird
10/10/2025	Inspection Completed-BCAL Sub. Compliance
10/10/2025	Exit conference with Ms. Ubah

**ALLEGATION: Resident A’s lisinopril and glipizide medications had a hold instruction, and the dates these medications were withheld were not consistent with the information recorded on the blood pressure and blood sugar reading log.**

**INVESTIGATION:** On 09/26/2025, I reviewed Resident A’s August 2025, and September 2025, medication logs. According to the medication logs and the pharmacy supplied label on the pill bottle for Resident A’s blood pressure and blood sugar medications, lisinopril and glipizide, respectively, there was an instruction for when the medication was not to be given. The medication log and pill bottle stated lisinopril was not to be given if Resident A’s systolic blood pressure was 120 and below and the glipizide medication was not to be given if his blood sugar was 70 and below.

On 09/26/2025, I reviewed Resident A’s medication logs. According to his August medication logs Resident A was prescribed 23 medications and he was refusing the majority of them. According to August medication logs the only medication he was taking as prescribed was his insulin. According to Resident A’s September medication log he was prescribed 14 medications, and he is now compliant with the medication regimen. However, I observed other variables that would cause inconsistencies with his blood pressure and blood sugar readings. I observed that Resident A had a lot of snacks, pop, cookies and chips in his bedroom, he is overweight, and his mobility is limited, he utilizes a walker and wheelchair. Furthermore, during my interview with Ms. Ubah, on 09/26/2025, she stated Resident A is also purchasing food from restaurants via Door Dash.

On 10/10/2025, I conducted an exit conference with Ms. Ubah. Ms. Ubah agreed with my findings.

<b>APPLICABLE RULE</b>	
<b>R 400.14310</b>	<b>Resident health care.</b>
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or

	other health care professional with regard to such items as any of the following: (a) Medications.
<b>ANALYSIS:</b>	Based upon the preponderance of evidence there is no evidence to determine that the licensee was not following the hold instructions for Resident A's lisinopril and glipizide medications.  During the months of August 2025, Resident A was refusing to take the majority of his medication.  The inconsistencies with the hold instructions and Resident A's blood pressure and blood sugar reading log could have been caused by other variables. Resident A consumes foods that are high in sodium and carbohydrates, he is overweight and has limited physical activity.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Resident A's medication logs and the pills counted were inconsistent. The medication logs indicated that Resident A received his medications, however the medication bottles were full.**

**INVESTIGATION:** On 09/26/2025, I interviewed Resident A. Resident A stated that he is trying to be compliant with his medications. Resident A stated he takes twenty-two medications and some of them are so big he has a difficult time swallowing them. Resident A stated he often asks staff to delay them, and she does not bring them back. Resident A stated Franca speaks very little English and maybe that is why she does not bring his medication back.

On 09/26/2025, I reviewed Resident A's September medication log and the pharmacy supplied label on the pill bottle for Resident A's gabapentin medication. According to the medication log and the pharmacy supplied label Resident A was to be given one tablet three times a day. The pharmacy supplied label on the pill bottle also stated that it was a 90-day supply and it stated the prescription was filled on 05/27/2025. According to this information Resident A should not have had any of this medication left in the pill bottle. I observed that other medications had the same discrepancy as the gabapentin medication.

On 09/26/2025, I interviewed the licensee designee Cynthia Ubah. Ms. Ubah stated that the medications are not consistent with the medication bottles because Resident A often refuses his medications. Ms. Ubah further stated the Veteran Administration (VA) nurse instructed her to put refused medications back into the pharmacy supplied bottles. Ms. Ubah also stated that the VA pharmacist sends a 90-day

supply of Resident A’s medications to the home. Ms. Ubah stated the 90-day supply is divided into three bottles, one for each month, however the date the prescription was filled is the same on all three bottles.

On 09/26/2025, I interviewed the VA medical foster home program coordinator Melissa Laird. Ms. Laird stated that she informed Resident A that medications can only be given an hour before or an hour after the prescribed time. Ms. Laird further stated she informed Resident A if he does not take his medications in that time frame it is considered as being refused medication.

On 10/10/2025, I conducted an exit conference with Ms. Ubah. Ms. Ubah agreed with my findings.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
<b>ANALYSIS:</b>	<p>Based upon the preponderance of evidence there is no evidence to determine that Resident A was not being given his medications pursuant to the label instructions.</p> <p>The medication logs and the number of pills contained in the medication bottles were inconsistent because the licensee was instructed by the health care professional to return refused medications to the pharmacy supplied bottles.</p> <p>Furthermore the VA pharmacist send a 90 day supply of all medications to the home. The 90-day supply comes in three separate bottles and all three bottles have the date that the prescription was filled.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Resident A’s medication logs were incomplete.**

**INVESTIGATION:** On 10/08/2025, I spoke with the VA nurse Danielle King. Ms. King stated that she and the VA nurse practitioner visited Resident A in the group home on 09/11/2025. Ms. King stated that she reviewed Resident A’s September medication logs and observed that direct care staff Sancus Osuokata’s (AKA) Sister’s initials were on the logs. Ms. King stated this could not be possible because Sister was not present in the home. Ms. King stated she asked Resident A when did Sister leave, and he replied she had left sometime last week. Ms. King stated she also

asked Ms. Ubah when did Sister leave. Ms. King stated after a lengthy discussion with Ms. Ubah they agreed Sister's leave could not have been after 09/09/2025, because Resident A fell on 09/09/2025, and it was Franca who helped him get up.

Ms. King further stated that Resident A's August medication logs did not document when Resident A refused his medications. Ms. King stated that during her September visit she noticed that Resident A's August medication logs had been re-written.

On 10/08/2025, I spoke with Ms. Ubah. I asked Ms. Ubah to forward me copies of Resident A's original August medication logs. Ms. Ubah stated she "shredded" them. Ms. Ubah stated that the logs were re-written because the times Resident A's medications were to be given had changed.

On 10/10/2025, I conducted an exit conference with Ms. Ubah. Ms. Ubah did not dispute my findings.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:  (b) Complete an individual medical log that contain all of the following information:  (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.  (vi) A resident's refusal to accept prescribed medication or procedures.

<p><b>ANALYSIS:</b></p>	<p>Based upon the preponderance of evidence the licensee did not comply with the following:</p> <p>Complete an individual medical log that contain all of the following information:</p> <p>The initials of the person who administers the medication, which shall be entered at the time the medication is given.</p> <p>A resident's refusal to accept prescribed medication or procedures.</p> <p>The initials of the person who administered Resident A's medications on September 9, 10 and the morning of the 11, 2025, were not on the medication logs. The initials on the logs could not have been Sancus Osuokata's because she was on a leave of absence.</p> <p>According to Ms. King on 09/11/2025, Resident A informed her Sister left sometime last week. After a lengthy discussion Ms. King and Ms. Ubah agreed that Sister's leave of absence could not have been after 09/09/2025, because Resident A fell on 09/09/2025, and it was Franca who helped him up.</p> <p>On 09/26/2025, Ms. Ubah stated to me Sister's leave of absence started on 09/11/2025.</p> <p>According to the VA nurse, Ms. King, Resident A's August medication logs also did not document when Resident A refused his medications.</p> <p>Based on the evidence, maintaining the original August medication logs would have given credibility to Ms. Ubah's reason for re-writing them and because she did not, she's unable to demonstrate that the logs were in compliance and didn't reveal errors.</p>
<p><b>CONCLUSION:</b></p>	<p><b>VIOLATION ESTABLISHED</b></p>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** On 09/26/2025, I conducted an onsite investigation. I observed that Ms. Okeke was the only staff present in the home.

On 09/26/2025, I reviewed direct care staff Franca Okeke employee record. There

was no documentation to verify that the licensee provided in-service training or made training available through other sources for Ms. Okeke. Furthermore Ms. Okeke was performing assigned tasks and was not competent in all areas of the required training.

On 10/10/2025, I conducted an exit conference with Ms. Ubah. Ms. Ubah did not dispute my findings.

<b>APPLICABLE RULE</b>	
<b>R 400.14204</b>	<b>Direct care staff; qualifications and training.</b>
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.
<b>ANALYSIS:</b>	Based upon the preponderance of evidence, the licensee did not provide in-service training or make training available through other sources for direct care staff Franca Okeke.  Furthermore, Ms. Okeke did not demonstrate she is competent in all areas of the required training and was performing assigned tasks.  On 09/26/2025, I conducted an onsite investigation. I observed that Ms. Okeke was the only staff present in the home.  Direct care staff Ms. Okeke employee record did not contain verification of training.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 09/26/2025, I conducted an onsite investigation. I observed that Ms. Okeke was the only staff on duty.

On 09/26/2025, I observed Resident A's September medication logs. I observed that Ms. Okeke was initialing the medication logs.

On 09/26/2025, I reviewed direct care staff Franca Okeke's employee file. Ms. Okeke employee file did not contain documentation that she had been trained in the proper handling and administration of medication.

On 10/10/2025, I conducted an exit conference with Ms. Ubah. Ms. Ubah did not dispute my findings.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:  (a) Be trained in the properly handling and administration of medication.
<b>ANALYSIS:</b>	Based upon the preponderous direct care staff, Ms. Okeke was not properly trained in the handling and administration of medication.  I observed that Ms. Okeke's initials were on Resident A's September medication logs.  Ms. Okeke employee file did not contain document to verify that she was trained.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 10/10/2025, I spoke with the VA nurse Danielle King. Ms. King stated that when she conducted her August visit, she reviewed Resident A's August medication logs. Ms. King stated that when she visited the home in September there was some discrepancies with the dates Resident A's lisinopril and glipizide medications were withheld while comparing them with Resident A's vital sign log. Ms. King stated she asked Ms. Ubah for Resident A's August medication logs. Ms. King stated that when Ms. Ubah gave her Resident A's August medication logs, she noticed that they had been re-written.

On 10/10/2025, I spoke with Ms. Ubah. Ms. Ubah stated that the original August medication logs had been shredded.

On 10/10/2025, I conducted an exit conference with Ms. Ubah. Ms. Ubah did not dispute my findings.

<b>APPLICABLE RULE</b>	
<b>R 400. 14316</b>	<b>Resident records.</b>
	(2) Resident records shall be kept on file in the home for two years after the date of a resident discharge from a home.
<b>ANALYSIS:</b>	<p>Based upon the preponderance of evidence the licensee did not keep Resident A's original August medication logs on file in the home two years after the date of a resident discharge from a home.</p> <p>Pursuant to licensing rule 400. 14316 (1) medication logs are to be maintained in the resident record.</p> <p>Ms. Ubah stated she shredded Resident A's original August medication logs.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 09/26/2025, the VA medical foster home program coordinator Melissa Laird explained to me the requirements needed to receive a contract to operate a medical VA home. Ms. Laird stated that the home must be a family home and informed me that Ms. Ubah and her children have living quarters in the basement of the home.

Pursuant to MCL 400. 733 "This act supersedes all local regulations applicable specifically to adult foster care facilities. Local ordinances, regulations, or construction codes regulating institutions shall not be applied to adult foster care large group homes, adult foster care small group homes, or adult foster care family homes. This section shall not be construed to exempt adult foster care facilities from local construction codes which are applicable to private residences." Based upon this statute Ms. Ubah needs approval from her local municipality to reside in the basement of her home.

On 10/10/2025, I spoke with Ms. Ubah. Ms. Ubah denied that her living quarters are in the basement. Ms. Ubah stated that direct care staff are used to provide 24-hours supervision and they also do not live in the basement. Ms. Ubah stated that she occupies one of the upstairs bedrooms. I informed Ms. Ubah that her occupancy in one of the upstairs bedrooms will decrease her capacity from four to two because Resident A occupies the double occupancy bedroom. And according to the floor plan

the other two bedrooms are single occupancy.

On 10/10/2025, I spoke with Ms. Laird. Ms. Laird stated again that Ms. Ubah has living quarters in the basement.

On 10/10/2025, I conducted an exit conference with Ms. Ubah. Ms. Ubah did not dispute my findings. Ms. Ubah stated, "If they need to pull my contract they can, but I don't live in the home."

<b>APPLICABLE RULE</b>	
<b>MCL 400.733</b>	<b>Local ordinances, regulations, or construction codes.</b>
	This act supersedes all local regulations applicable specifically to adult foster care facilities. Local ordinances, regulations, or construction codes regulating institutions shall not be applied to adult foster care large group homes, adult foster care small group homes, or adult foster care family homes. This section shall not be construed to exempt adult foster care facilities from local construction codes which are applicable to private residences.
<b>ANALYSIS:</b>	Based upon the preponderance of evidence this home is not exempt from local construction codes which are applicable to private residence.  On 09/26/2025, and again on 10/10/2025, Ms. Laird stated Ms. Ubah have living quarters in her basement.  The licensee does not have approval from the City of Westland to reside in the basement of this home.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

IV. **RECOMMENDATION**

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



Edith Richardson  
Licensing Consultant

10/14/2025

Date

Approved By:



Ardra Hunter  
Area Manager

10/14/2025

Date