GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 6, 2025

Kimberly Brown
Bridgefort Inc
PO Box 760328
Lathrup Village, MI 48076

RE: License #: AM820078391
Investigation #: 2025A0992033
Commor-Mackay

Dear Ms. Brown:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM820078391
Investigation #:	2025A0992033
Complaint Receipt Date:	06/25/2025
Investigation Initiation Date:	06/25/2025
Report Due Date:	08/24/2025
Licensee Name:	Bridgefort Inc
Licensee Address:	15562 Hemlock Street Detroit, MI 48235
Licensee Telephone #:	(586) 216-6499
Administrator:	Kimberly Brown
Licensee Designee:	Kimberly Brown
Name of Facility:	Commor-Mackay
Facility Address:	2432 Commor Hamtramck, MI 48212
Facility Telephone #:	(313) 365-7757
Original Issuance Date:	10/13/1997
License Status:	REGULAR
Effective Date:	08/08/2024
Expiration Date:	08/07/2026
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On June 20, 2025, Resident A was denied re-entry to the AFC Home due to a prior incident and was later taken to Henry Ford Hospital. Resident A was improperly discharged	Yes

III. METHODOLOGY

06/25/2025	Special Investigation Intake 2025A0992033
06/25/2025	Special Investigation Initiated - Telephone Office of Recipient Rights, April Dudley was not available. Message left.
06/25/2025	Contact - Telephone call made Resident A's guardian, Relative A
07/08/2025	Contact - Face to Face Direct care staff, Latonya Simmons.
07/10/2025	Contact - Telephone call received Home manager, Joy Tyner.
07/18/2025	Contact - Telephone call made Area manager, Teresa Brown
07/21/2025	Contact - Document Received Explanation of incident from licensee designee, Kimberly Brown
07/22/2025	Contact - Telephone call made Ms. Brown

ALLEGATION: On June 20, 2025, Resident A was denied re-entry to the AFC Home due to a prior incident and was later taken to Henry Ford Hospital. Resident A was improperly discharged.

INVESTIGATION: On 06/25/2025, I contacted Resident A's guardian, Relative A regarding the allegation. Relative A stated Resident A had a mental health crisis and is currently hospitalized. She stated the home did not kick him out; and that they helped her with having him hospitalized for treatment. She stated she believes the

home is issuing a 30-day discharge. Relative A stated she is unable to care for Resident A because he cannot control his behavior and often attacks her. She stated the home staff were helpful and suggested I contact the home for additional information.

On 07/08/2025, I completed an unannounced onsite inspection and interviewed direct care staff, Latonya Simmons. Ms. Simmons stated she was on shift the day the incident occurred. She stated Relative A and Resident A arrived at the home and Relative A appeared to be emotional and panicking. She stated Resident A was rowdy and bold towards Relative A; she stated he left out of the home and stood by Relative A's car. Ms. Simmons stated Relative A asked her to call the police and she did. She stated when the police arrived, they spoke with Relative A and Resident A. She stated the police instructed Resident A not to enter the home and to leave the premises. She stated the police did not wait for him to leave, they stated they had another call and left. She stated before they left, they reiterated that Resident A could not enter the home. Ms. Simmons stated Relative A appeared to be fearful and did not want to leave the home with Resident A. Ms. Simmons stated Relative A mentioned that Resident A hit her and she is unable to care for him. Ms. Simmons stated she contacted licensee designee, Kimberly Brown and area manager, Teresa Brown and made them aware of what was going on. She stated neither Kimberly nor Teresa said Resident A could not return to the home. She stated the police advised him not to enter the home. Ms. Simmons stated Resident A was new to the home and had been there approximately two weeks.

On 07/10/2025, I received a call from home manager, Joy Tyner. I interviewed her regarding the allegation, which she denied. She stated Resident A was admitted to the home on 06/16/2025 and had been on leave of absence (LOA) off and on with Relative A. She stated Resident A returned to the home on 06/19/2025 with Relative A and he did not want to stay, so he left again. She stated on 06/20/2025, both Relative A and Resident A returned to the home. She stated Resident A was noticeably upset with Relative A for bringing him back to the home. Ms. Tyner stated Resident A was fighting with Relative A. She stated Relative A was frightened and frustrated. Ms. Tyner stated the staff called the police and when they arrived, they spoke with Relative A and Resident A. Ms. Tyner stated Relative A remained in the home while Resident A was outside, he was still angry. Ms. Tyner stated she is uncertain how Resident A left the home whether he left with Relative A or not. However, she stated she believed he was admitted into the hospital. Ms. Tyner stated Resident A was not denied entry into the home. She stated Resident A made it very clear that he did not want to be there, but he was not denied entry into the home.

On 07/18/2025, I contacted area manager, Teresa Brown and interviewed her regarding the allegation, which she denied. Ms. Brown stated Resident A was relatively new to the home. She stated when he was first admitted, he stayed one night, and he called Relative A all night. She stated Relative A came and got him and he stayed with her. She stated he returned and left again. Ms. Brown stated on

the day of the incident, Relative A and Resident A returned to the home and Relative A was crying. Ms. Brown stated Relative A showed her bruises and stated Resident A violently attacked her. Ms. Brown stated Relative A was afraid. Ms. Brown stated the staff called the police and when they arrived, they spoke with Relative A and Resident A. She stated the police did not resolve the issue. She stated the police stated they were short staffed and left. Ms. Brown stated Relative A still seemed to be frightened of Resident A. Ms. Brown stated Resident A was not in a mental space to be verbally redirected. She stated she contacted direct care staff Ron Young, from another home to come and assist. She stated she thought Resident A would be more receptive to a male presence. Ms. Brown stated Mr. Young tried to redirect him, but he was not receptive. She stated a fire truck was coming down the street and Mr. Young flagged it down. She stated Mr. Young explained what was going on to the fireman and he called someone to assist with the situation. Ms. Brown stated moments later an unmarked officer arrived and assisted with resolving the situation, she stated the officer transported Resident A to be hospitalized. Ms. Brown stated Resident A was not denied entry. She stated it was clear he did not want to be in the home, and he left every chance he had. She stated at the time of the incident he appeared unstable and was in crisis. Ms. Brown stated Resident A has not returned to the home.

On 07/21/202, I received an email from licensee designee, Kimberly Brown as it pertains to the allegation, summarizing what occurred. Ms. Brown stated Resident A was admitted into the home on 06/16/2025. She stated he had made it clear at the time of admission that he would not be there long. She stated about 24 hours after he was admitted Relative A came to the home in the middle of night and Resident A left with her. She stated on 06/20/2025, she received a call from Ms. Simmons stating that Relative A and Resident A were at the home. She stated Relative A was inside the home and was afraid of Resident A. She stated Resident A assaulted Relative A the night before. Ms. Simmons stated Relative A wanted staff to call the police; and they were called. Ms. Brown stated she spoke with Relative A and she indicated her fear. She stated she had been up all night because Resident A had been actively aggressive towards her, and he would not sleep. While speaking with Relative A she would not leave the home, Resident A was outside. Ms. Brown stated Ms. Simmons stated she told them he could not return. Ms. Brown stated she made Ms. Simmons aware that she did not say he could not return. Ms. Brown stated after speaking with Relative A, a couple of times during this episode she suggested Resident A may need to be hospitalized and Relative A agreed. Ms. Brown stated Relative A stated she would petition him. Ms. Brown stated based on Resident A's behaviors including packing up and leaving in the middle of the night; leaving food all over his room after being told not to do that; his alleged assaultive behavior; Relative A's fear of him, Relative A being unable to reason with him or direct him in any form, his statements that he did not want to be there were all factors that contributed to the belief that at the time Resident A had no desire to be at the home. Ms. Brown stated she concluded that the home would not be a good fit for him. She stated based on Relative A's statements and his behaviors it was determined that hospitalization may be warranted.

On 07/22 /2025, I contact Ms. Kimberly Brown regarding the email I received. I confirmed the series of events as Ms. Brown summarized in her email. She stated although she was not present, she spoke with Ms. Simmons as it unfolded. Ms. Brown confirmed that based on Resident A's behaviors, she concluded that the home would not be a good fit for him. I asked Ms. Brown if she issued an emergency discharge and she said no. I explained that the emergency discharge documentation must demonstrate how there is a substantial risk to Resident A due to the inability of the home to meet his needs or assure the safety and well-being of other residents of the home; substantial risk, or an occurrence, of self-destructive behavior; an occurrence, of serious physical assault; or the destruction of property. Ms. Brown stated she did not complete a discharge notice that she can recall. I explained that based on the findings, she did not properly document Resident A's behaviors that constitute a substantial risk and/or warrant an emergency discharge.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.**

ANALYSIS:	During this investigation, I interviewed licensee Kimberly Brown; area manager, Teresa Brown; home manager, Joy Tyner; direct care staff, Latanya Simmons; Resident A's guardian, Relative A regarding the allegation. Relative A stated Resident A was not kicked out of the home. She stated he was in crisis and the staff helped her with having him hospitalized for treatment. Ms. Kimberly Brown confirmed she concluded that the home would not be a good fit for him. She stated she did not complete a discharge notice that she can recall. Based on the investigative findings, Ms. Brown did not document behaviors that constitute a substantial risk and/or warrant an emergency discharge. There is sufficient evidence to support the allegation, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

7/25/2025

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Denasha Walker Date
Licensing Consultant

Approved By:

8/6/2025

_____

Ardra Hunter Date
Area Manager