GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 27, 2026

Aida Moussa
My Doctors Inn
8384 Metropolitan Parkway
Sterling Heights, MI 48312

RE: License #: AH500386237
Investigation #: 2026A1035046
My Doctors Inn

Dear Licensee:

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 (517) 335-5985.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500386237
Investigation #:	2026A1035046
Complaint Receipt Date:	06/18/2026
Investigation Initiation Date:	07/30/2026
Report Due Date:	08/18/2026
Licensee Name:	MDI Sterling Heights, LLC
Licensee Address:	4000 Town Center Southfield, MI 48075
Licensee Telephone #:	(248) 262-2357
Administrator/ Authorized Representative:	Aida Moussa
Name of Facility:	My Doctors Inn
Facility Address:	8384 Metropolitan Parkway Sterling Heights, MI 48312
Facility Telephone #:	(586) 838-5900
Original Issuance Date:	03/30/2017
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was abused. Facility did not follow Incident and Accident policy and procedures.	Yes
Facility has bed bugs and has not followed policy and procedure addressing infestation.	No
Additional Findings	Yes

III. METHODOLOGY

06/18/2026	Special Investigation Intake 2026A1035046
06/24/2026	Contact - Document Sent
07/30/2026	Contact - Face to Face
8/6/2026	Contact – Email sent to AR requesting education document and competency test for Staff Person's (SP)1-12.
08/27/2026	Inspection Complete. BCAL Sub Compliance.
08/27/2026	Exit Conference.

ALLEGATION:

Resident A was abused. Facility did not follow Incident and Accident policy and procedures.

INVESTIGATION:

On June 18, 2026, the Department received an anonymous complaint through the online complaint system which read:

"There is a video going around of the residents being abused at the facility."

On July 30, 2026, an onsite investigation was conducted. While onsite I interviewed Aida Moussa Administrator who states she is unaware of resident abuse occurring nor a video circulating related to resident abuse. The Administrator states she has a no tolerance rule related to abuse.

While onsite I interviewed SP1 who states she has not heard or seen a video related to resident abuse within the community.

While onsite I interviewed SP2 who states she is aware of an abuse situation that occurred in the memory care unit to Resident A. SP2 states she had heard there was a video circulating but had not seen it. SP2 denies formal training on abuse, neglect, and reporting since employment.

While onsite I interviewed SP3 who states she is unaware of abuse happening within the facility.

While onsite I interviewed SP4 who states she is unaware of abuse occurring. SP4 states she is new to the facility; she has had orientation related to floor tasks and duties. SP4 states her formal orientation will occur in the first week of August.

While onsite I interviewed SP5 who states the “abuse” happened on the memory care unit. The employee involved no longer works at the facility. SP5 was unable to provide the name of the employee and resident involved.

While onsite I interviewed SP6 who states she is unaware of abuse occurring in the facility.

While onsite I interviewed SP7 who states she is aware of the abuse that occurred to Resident A. SP7 states the abuse happened on the memory care unit. SP12 was upset with Resident A and started speaking to in a “nasty” way then push Resident A into the shower “wheelchair and all” and proceeded to shower her. SP12 was the aggressor and was terminated post event. SP7 states she has not received formal training at this facility related to abuse and reporting.

While onsite I interviewed SP8 who states she has not heard of abuse occurring. SP8 states she knows how to report abuse to the supervisor if abuse occurred. SP8 states she has not received a formal orientation where policies and procedures are reviewed. Orientation was a “quick” review of assignment task and duties then a set was assigned to her.

While onsite I interviewed SP9 who states she has not received orientation, orientation will happen at the beginning of August. SP9 states she is unaware of abuse occurring.

While onsite I interviewed SP10 who states there was an incident where SP12 was accused of being verbally mean to a resident. SP12 was terminated on 6/17/2026. SP10 states there was no formal investigation conducted. SP10 states she is unaware of this event being recorded.

While onsite I reinterviewed the Administrator inquiring about the abuse incident that was reported and provided the names staff members had provided. The

Administrator states she terminated SP12 related to a staff member stating she was being mean to a resident. The Administrator states a formal investigation was not conducted, the reporting employee has been employed for a long time, therefore, she took her word and moved forward with termination.

On August 5, 2026, a phone interview was conducted with SP11 who states she witnessed and recorded SP12 abusing Resident A. SP12 had an “attitude” from the beginning of her shift because she was the “float” caregiver. SP12 was observed telling Resident A she was going to “beat her up” then backed into the shower where SP12 proceeded to turn the shower on. Resident A continued to yell. SP11 states she showed the recording to fellow coworker post occurrence and SP10. SP10 forwarded the recording to the Administrator. SP12 was terminated the same day.

Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Through interviews multiple staff members state Resident A was verbally abused. SP11 states she was a direct witness to the abuse and recorded the event. SP11 stated the recording was provided to management. The Administrator did not follow facility Abuse, Neglect, and Exploitation policy and procedure. A formal investigation was not conducted. Based on interview and record review this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility has bed bugs and has not followed policy and procedure addressing infestation.

INVESTIGATION:

On June 18, 2026, the Department received an anonymous complaint through the online complaint system which read:

“The facility has bed bugs.”

While onsite I interviewed the Administrator who states the facility has an isolated bed bug occurrence in one of the assisted living rooms. The Administrator states they had contacted Rose Pest Solutions. Rose Pest Solutions has treated the room and will be back on July 30, 2026, to complete a final inspection. Resident B is scheduled to move out today related to the family being unhappy with how the facility handled the bed bugs and recommendations of moving Resident B from the infested room.

Rose Pest Solutions reports had been reviewed, as of July 30th there were no indication of bed bugs.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin. **(2) Pest control procedures shall comply with MCL 324.8301 et seq.**
ANALYSIS:	Bed bugs had been identified in an isolated room. The facility followed policy and procedure identifying, addressing, and eradicating bed bug infestation. Based on record review and interviews this allegation has not been substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Through interview with SP1, SP3, SP4, SP5, SP6, SP7, and SP10 formal orientation and training had not occurred. Two staff members stated their education will occur in August.

While at the facility core initial education of Resident Rights, Abuse, Reporting, and Safety was requested. SP10 stated she will gather the information and email it to writer. On August 6, 2026, an email was sent to the Administrator requesting the initial signed education and competency check off for all interviewed staff as well as SP12. The facility has not provided the requested documentation for each employee listed.

APPLICABLE RULE	
R 325.1931	**R 325.1931 Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.** **(7) The home's administrator or its designees are responsible for evaluating employee competencies.**
ANALYSIS:	The facility did not provide initial education and competency check-off for interviewed staff and SP12 as requested. Multiple interviewed staff state they have not received formal education related to Resident Rights, Abuse, Reporting, and Safety. Based on staff interviews and not receiving requested documents violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend the status of this license remain unchanged.

08/10/2026

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing
Section

Approved By:

08/27/2026

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section