



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 17, 2026

Megan Charboneau
Linda Margaret's Retirement Community LLC
722 S. Huron St.
Cheboygan, MI 49721

RE: License #: AM160417504
Investigation #: 2026A0360010
Linda Margaret's Retirement Community

Dear Ms. Charboneau:

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 (616) 356-0100.

Sincerely,

Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit #13
Grand Rapids, MI 49503
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM160417504
Investigation #:	2026A0360010
Complaint Receipt Date:	12/23/2025
Investigation Initiation Date:	12/26/2025
Report Due Date:	02/21/2026
Licensee Name:	Linda Margaret's Retirement Community LLC
Licensee Address:	3723 Long Lake Rd Cheboygan, MI 49721
Licensee Telephone #:	(231) 445-2010
Administrator/ Licensee Designee:	Megan Charboneau
Name of Facility:	Linda Margaret's Retirement Community
Facility Address:	3723 Long Lake Rd Cheboygan, MI 49721
Facility Telephone #:	(231) 445-2010
Original Issuance Date:	11/09/2023
License Status:	REGULAR
Effective Date:	05/09/2024
Expiration Date:	05/08/2026
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A received medication labeled for a different resident.	Yes

III. METHODOLOGY

12/23/2025	Special Investigation Intake 2026A0360010
12/26/2025	APS Referral online
12/26/2025	Special Investigation Initiated - Letter APS
12/26/2025	Contact - Document Received Relative A
01/08/2026	Inspection Completed On-site Steve McLoud Home manager, DCSM Alicia Steyes, DCSM Si'asia Page
01/08/2026	Contact - Telephone call made Megan Charboneau
02/10/2026	Inspection Completed On-site Documents received
02/11/2026	Exit Conference Megan Charboneau
02/13/2026	Contact - Telephone call made Relative A

ALLEGATION:

Resident A received medication labeled for a different resident.

INVESTIGATION:

On 12/26/25, I contacted Relative A who stated that when Resident A's medications were picked up from the home after being discharged there was a bottle of Sertraline 100mg tablets that were not prescribed to Resident A but rather another resident. Relative A stated that Resident A's name was handwritten on the bottle label in marker and a note that the tablets were already cut to 25 mg which is what Relative A's prescribed Sertraline dose was. Relative A sent me a photo of the prescription pill bottle. Relative A stated that Resident B's prescription Escitalopram was not administered 12/16-12/19/25. Relative A stated that she has moved Resident A and Resident B from the facility, and they have been admitted to a skilled nursing facility. Relative A stated that both residents had some weight loss over the past three months. She stated that she brought Ensure to the facility but that it was not used every day based on the amount that she dropped off at the facility.

On 1/8/26, I conducted an unannounced onsite inspection at the facility. The home manager Steve McLoud stated that he is not aware of Resident A being administered another resident's medication. The photo of the prescription pill bottle was shown to Mr. McLoud, and he stated that was the first that he had seen that bottle. He stated the name on the bottle was a former resident who passed away on 11/16/25. I then reviewed the medication administration records and cross referenced them with all resident medication at the facility. I did not observe any other prescription pill bottles with handwritten names on them. All the resident medications were accounted for. Mr. McLoud stated that Resident B's Escitalopram ran out on 12/19/25 despite several contacts with the pharmacy to attempt to get it refilled.

While at the facility I interviewed direct care staff member (DCSM) Alicia Steyes. Ms. Steyes stated she had never seen the prescription pill bottle with the handwritten name on it. She stated that she would never allow that to occur and would report it to her manager if she seen that.

While at the facility I interviewed DCSM Si'Asia Page. Ms. Page stated she had never seen the prescription pill container with Resident A's name handwritten on it. She stated that the family did bring in Ensure for both Resident A and Resident B to drink but Resident B would often refuse to drink it.

On 1/8/26, I contacted the licensee, Megan Charboneau. I provided Ms. Charboneau with a copy of the photo of the prescription medication with the handwritten name of Resident A on it. Ms. Charboneau denied any knowledge of the bottle and stated that she would not allow that if she had been aware of it. Ms. Charboneau stated she can only think of one former employee who was recently terminated who may have

done that. She stated she would discuss it with all her staff and let them know that it was not allowed.

On 2/10/26, I conducted an onsite inspection at the facility and received Resident A and Resident B's resident care agreement, written assessment plan, health care appraisal, weight records and medication administration records for November and December 2026. Resident A's weight records indicated that he lost 15 pounds during the four months he was at the facility. Resident B's weight records indicated that she lost 17 pounds during the four months at the facility. Resident A's medication administration record for November and December 2025 documented that he was administered his Sertraline 25 mg as prescribed. Resident B's medication administration record documented that her Escitalapram 5 mg was held on 12/16-12/19/25.

On 2/11/25, I was contacted by Ms. Charboneau. Ms. Charboneau stated that she has discussed at length with Mr. McLoud and all the staff regarding medication-related issues. She stated thinks it was an isolated incident from the former staff person.

On 2/13/25, I contacted Relative A. Relative A stated that both Resident A and B are still placed in a skilled nursing home. She stated Resident B has continued weight loss, but they are keeping a close eye on it. Relative A stated she has no other concerns with the facility.

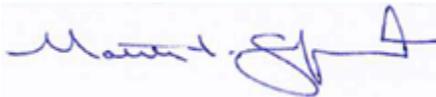
APPLICABLE RULE	
R 400.675	Resident medications.
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.

ANALYSIS:	Interviews with Relative A, Mr. McLoud, Ms. Steyes, Ms. Page, and Ms. Charboneau revealed that a prescription medication for a previous resident was being used for Resident A. All the resident medication was cross referenced with the medication administration records and the situation appears to be an isolated incident possibly by a former staff member.
CONCLUSION:	VIOLATION ESTABLISHED

On 2/11/26, I conducted an exit conference with Ms. Charboneau. Ms. Charboneau concurred with the findings of the investigation and agreed to submit a written corrective action plan for approval.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

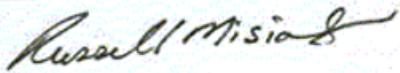


2/13/26

Matthew Soderquist
Licensing Consultant

Date

Approved By:



2/13/26

Russell B. Misiak
Area Manager

Date