



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2026

Lynn VanBlargan
Twin Lake Assisted Living
3790 E. McMillan Rd.
Twin Lake, MI 49457

RE: License #:	AS610387285
Investigation #:	2026A0356052
	Twin Lake Assisted Living

Dear Ms. VanBlargan:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth Elliott". The signature is written in black ink and is positioned below the word "Sincerely,".

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610387285
Investigation #:	2026A0356052
Complaint Receipt Date:	07/21/2026
Investigation Initiation Date:	07/23/2026
Report Due Date:	09/19/2026
Licensee Name:	Twin Lake Assisted Living
Licensee Address:	3790 E. McMillan Rd. Twin Lake, MI 49457
Licensee Telephone #:	(231) 788-8609
Administrator:	Lynn VanBlargan
Licensee Designee:	Lynn VanBlargan
Name of Facility:	Twin Lake Assisted Living
Facility Address:	3790 E. McMillan Rd. Twin Lake, MI 49457
Facility Telephone #:	(231) 788-8609
Original Issuance Date:	09/18/2017
License Status:	REGULAR
Effective Date:	03/18/2026
Expiration Date:	03/17/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Staff at the facility practice unsafe medication administration practices.	Yes

III. METHODOLOGY

07/21/2026	Special Investigation Intake 2026A0356052
07/23/2026	Special Investigation Initiated - Telephone Joanna Harrington, Health West case manager.
07/24/2026	APS Referral Centralized Intake, APS referral made.
07/24/2026	Contact - Telephone call made Joanna Harrington, HW, case manager.
08/20/2026	Inspection Completed On-site
08/20/2026	Contact - Face to Face Lynn VanBlargan, Licensee, Residents A, B, C and D.
08/20/2026	Contact - Document Received Reviewed training documents and resident MARs.
09/08/2026	Contact-Telephone call made Bri Louk, DCW (direct care worker)
09/14/2026	Contact-Document sent Lynn VanBlargan, email.
09/16/2026	Exit conference-Lynn VanBlargan, Licensee.

ALLEGATION: Staff at the facility practice unsafe medication administration practices.

INVESTIGATION: On 07/21/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported on 07/16/2026, they witnessed staff carry out 4 or 5 cups of distributed medications for the morning medication administration at the same time from the kitchen into the dining area where the residents were seated to eat breakfast. The complainant reported they witnessed staff set all of the cups of

medication on the table by each other and was looking at them, as though she was trying to remember whose medications were whose. The complainant reported the cups were clear with no way to personally identify whose medications were in which cup. In addition, the complainant reported that on June 23, 2026 they witnessed the homeowner, Lynn setting up medications for a later time in the day, possibly the oncoming shift, again, all in clear cups and then locking them in what looked like a small cabinet.

On 07/24/2026, I interviewed Joanna Harrington, Health West case manager via telephone. Ms. Harrington stated she went to the facility on 07/16/2026 at approximately 9:30a.m. to see Resident A & E. They were sitting at the table and Ms. Harrington witnessed staff, Bri (Louk) carrying clear cups with medications in them to the table. Ms. Harrington stated Ms. Louk was looking at the medications in the cups obviously not knowing whose medications were whose. She appeared uncertain and then said, "oh, ok, ok" and set them on the table in front of the residents. Ms. Harrington stated Ms. Louk had 4 or 5 cups of medications in her hands and there were 4 residents at the table at that time.

On 08/20/2026, I conducted an unannounced inspection at the facility and interviewed Licensee Lynn VanBlargan. Ms. VanBlargan stated Ms. Louk was working and Ms. VanBlargan was not at the facility at the time this occurred. Ms. VanBlargan stated Ms. Louk is a new staff member and was fully trained on 04/22/2026 on the proper administration of resident medications. Ms. VanBlargan stated the medications are in pop packs. Staff are to pop the medications into cups and administer them to the residents one at a time. I observed the medication cart and did not see any cups of medications set up in the cart.

On 08/20/2026, I interviewed Resident A & B at the table at the facility. Resident A stated she likes to eat first and then take her medications, so the medications sit in a cup on the table in front of her and then she takes them. Resident A stated she used to take the cup of medications to her room, but Heather (a former staff member) told her she had to take them at the table, so she does. Residents A & B stated some of the residents at the facility are more "mixed up" than they are, that the clear cups the medications are in do not have the residents' names on them and staff set them in "our spots" at the table or put the cups, "in our hands."

On 08/20/2026, I interviewed Resident C in her room at the facility. Resident C stated she takes her medications at the table in the dining room and staff watch the other residents take their medications all at the same time. Resident C stated her medications are put in a cup and she takes them either at the dining room table or in her room while sitting in her chair.

On 08/20/2026, I interviewed Resident D at the table at the facility. Resident D stated Ms. VanBlargan and staff bring her medications in a cup with water. The medications are brought out one at a time, not all at once and each resident takes

their medications one at a time. Resident D stated Ms. Louk was no different and administered her medications the same way, one resident at a time.

On 08/20/2026, I reviewed staff Bri Louk's training records at the facility and saw Ms. Louk had in-house medication training and reviewed the acknowledgment of training competencies signed by Ms. Louk on 04/22/2026.

On 08/20/2026, I reviewed the MAR (medication administration records) for the month of August 2026 for Residents A, B, C, D, E and F. The MARs document resident medications have been administered as prescribed.

On 09/08/2026, I interviewed Ms. Louk via telephone. Ms. Louk stated on 07/16/2026, she did not administer resident medications as she normally does, She stated she always dispenses the medications individually, one resident at a time but on that morning, she was behind in the administration of the resident's medications and put the resident's medications in cups all at the same time and gave them to the residents while they were at the dining room table. Ms. Louk stated she knew whose medications were whose and was double-checking the cups before giving them to the residents because she knew who got what medications. Ms. Louk stated she was not confused as to the resident medications as was alleged. Ms. Louk stated they do not set up medications for future administration, and resident medications are dispensed at the time they are taken out of the original pharmacy containers and put into cups. Ms. Louk has not seen anyone, including Ms. VanBlargan set up medications. Ms. Louk stated she started working at the facility in April 2026, she was trained on how to administer resident medications and has since been additionally trained in the administration of resident medication.

On 09/14/2026, I corresponded with Ms. VanBlargan via email. Ms. Van Blargan stated she worked on 06/23/2026 all day, she did not have another staff member coming in to work and did not set up pills for another shift. Ms. VanBlargan stated there would have been no prepping for another person to come after her as the complainant alleged. Ms. VanBlargan stated the only time she has ever had to put a cup of resident medications in the med cart has been while she was administering the resident's medications, and the resident had to go to the bathroom so she locked the cup with the meds in it, in the medication cart in their box, with their name on it until they came out. Ms. VanBlargan stated she has always taken good care of the residents and has never had a medication error.

On 09/16/2026, I conducted an exit conference with Lynn VanBlargan, licensee via telephone. Ms. VanBlargan stated Ms. Louk has completed additional training through the Educational Providers of America medication administration course and plans to review the medication administration protocol at the next staff meeting. Ms. VanBlargan stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

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:	The complainant reported staff distributed medications to residents in unlabeled cups at the same time. The complainant reported that Ms. VanBlargan set up the medications for a later time in clear cups and locked them in the medication cabinet. Ms. Louk stated she put the residents' medications in cups all at the same time and gave them to the residents while they were at the dining room table. Ms. Louk has not seen Ms. VanBlargan or any staff set medications up and place them in the medication cart. Ms. VanBlargan denied that she ever set resident medications up in the med cart for future administration. During an unannounced inspection, I looked in the medication cart and did not see any medications set up in cups for future administration. Based on investigative findings, there is a preponderance of evidence to show that Ms. Louk placed more than one resident's medications in unlabeled cups and administered them to the residents while they were sitting at the dining room table. A violation of this applicable rule is established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



09/16/2026

Elizabeth Elliott
Licensing Consultant

Date

Approved By:



09/16/2026

Jerry Hendrick
Area Manager

Date