GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 10, 2026

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

RE: License #:	AS610387285
Investigation #:	2026A0356059
	Twin Lake Assisted Living

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

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 #:	2026A0356059
Complaint Receipt Date:	09/16/2026
Investigation Initiation Date:	09/16/2026
Report Due Date:	11/15/2026
Licensee Name:	Twin Lake Assisted Living
Licensee Address:	3790 E. McMillan Rd. Twin Lake, MI 49457
Licensee Telephone #:	(231) 788-8609
Administrator:	Lynn VanBlargan, Administrator
Licensee Designee:	Lynn VanBlargan, Designee
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?
Resident A did not eat breakfast before she left the facility for day program.	Yes
Resident A's medication was not administered as prescribed.	Yes
Additional Finding	Yes

III. METHODOLOGY

09/16/2026	Special Investigation Intake 2026A0356059
09/16/2026	APS Referral APS referral denied.
09/16/2026	Special Investigation Initiated - Telephone Licensee Lynn VanBlargan informed me of this incident. Sent the IR.
09/17/2026	Contact - Document Received Faxed IR received.
09/30/2026	Inspection Completed On-site
09/30/2026	Contact - Face to Face Resident A
10/14/2026	Contact - Telephone call made Monique Collins, APS, DHHS, Muskegon County.
10/15/2026	Contact-Document received APS referral-M. Collins. Already open complaint.
10/21/2026	Contact - Document Received Resident A's MARs, Resident A's assessment plan.
10/21/2026	Contact - Telephone call made Licensee Lynn VanBlargan.
11/05/2026	Contact-Telephone call made Licensee Lynn VanBlargan. Legal Guardian Susan Griswold.
11/10/2026	Exit conference-Lynn VanBlargan, Licensee.

ALLEGATION: Resident A did not eat breakfast before she left the facility for day program.

INVESTIGATION: On 09/16/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community and Health Systems) online complaint. The complainant reported that this morning (09/16/2026) Resident A was not fed breakfast.

On 09/16/2026, I interviewed Lynn VanBlargan, Licensee via telephone. Ms. VanBlargan called to inform me of the incident and reported that the bus that transports Resident A to her day program usually arrives at 7:40 a.m. but they have been arriving earlier and sometimes as early as 6:50 a.m. Ms. VanBlargan stated on 09/16/2026 Resident A's transportation arrived and took Resident A to the bus before she was able to eat breakfast. Ms. VanBlargan stated Resident A always gets breakfast before going to her day program.

On 09/30/2026, I conducted an onsite inspection at Resident A's day program and interviewed Kelly Dahlman, program coordinator and Nathaniel Ebeling, CEO, was in attendance. Ms. Dahlman stated there have been two incidents, one on 08/27/2026 and the other on 09/16/2026 that Resident A came to day program without eating breakfast. Ms. Dahlman stated on 08/27/2026, Ms. VanBlargan was out of town and the staff that she had at the facility were sleeping on the couch. Resident A stated she got up and left for day program without any breakfast. Ms. Dahlman stated no one called the day program to check up on Resident A, they did not know she had left the facility, and she had no breakfast. Ms. Dahlman stated on 09/16/2026, the bus arrived early and Resident A did not have time to eat breakfast. Ms. Dahlman stated APS had been out to investigate the 08/27/2026 incident.

On 09/30/2026, I interviewed Resident A in the conference room at the day program. Resident A stated on 08/27/2026, "someone was supposed to be there at the house," it was Jayce VanBlargan, the Licensee's son, and he was sleeping on the couch. Resident A stated Mr. VanBlargan was supposed to wake her up, but he did not and she did not get to eat breakfast before she went to day program. Resident A stated Ms. VanBlargan was out of town. Resident A stated on 09/16/2026, the van came early to pick her up for day program, she got dressed, combed her hair, got her dentures in and went to the bathroom but she did not have time for breakfast. Resident A stated now if/when her ride shows up early, they wait in the driveway for her so she is completely ready when she leaves for day program.

On 10/14/2026, I interviewed Monique Collins, APS (Adult Protective Services) Worker via telephone. Ms. Collins stated the incident she is investigating was the incident dated 08/27/2026, the allegation was that staff are not getting up in the morning with Resident A and feeding her. Ms. Collins stated Ms. VanBlargan was not working on this date, but that Jayce VanBlargan was working. Ms. Collins reported that according to Ms. VanBlargan, Resident A went out of the AFC to the

bus on her own prior to eating breakfast and before staff could get breakfast ready for her. Ms. Collins stated this is still an open and ongoing investigation.

On 11/05/2026, I interviewed Ms. VanBlargan via telephone. Ms. VanBlargan stated on 08/27/2026, she was not at the facility and Mr. J. VanBlargan was working. Ms. VanBlargan stated Mr. J. VanBlargan had become ill and was in the bathroom on the morning of 08/27/2026 and when Mr. J. VanBlargan came out of the bathroom to assist Resident A and get breakfast for her, the van had come early, and Resident A was already out of the facility and getting into the van. Ms. VanBlargan acknowledged that Resident A did not get breakfast on the morning of 08/27/2026.

On 11/05/2026, I interviewed Susan Griswold, legal guardian for Resident A. Ms. Griswold stated she was informed about Resident A not getting breakfast on 08/27/2026 and 09/16/2026 from Ms. VanBlargan.

11/10/2026, I conducted an exit conference with Lynn VanBlargan, Licensee Designee. Ms. VanBlargan acknowledged the incident and stated she will review the report and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	The complainant reported on 09/16/2026 Resident A was not fed breakfast. Ms. Dahlman stated there have been two incidents, on 08/27/2026 and 09/16/2026 that Resident A came to day program without eating breakfast. Resident A reported she did not eat breakfast before leaving the facility for day program on 08/27/2026 and 09/16/2026. Ms. VanBlargan acknowledged that on 08/27/2026 and 09/16/2026 Resident A left the AFC home without having breakfast due to the early arrival of Resident A's transportation to day programming. Ms. Collins reported Resident A did not get breakfast on 08/27/2026. Ms. Griswold reported she was notified that Resident A did not get breakfast on 08/27/2026 and 09/16/2026.

	Based on investigative findings, Resident A did not eat breakfast upon leaving the facility on 08/27/2026 and 09/16/2026 for day programming and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's medication was not administered as prescribed.

INVESTIGATION: On 09/16/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community and Health Systems) online complaint. The complainant reported that Resident A was not given her morning medication on 09/16/2026.

On 09/16/2026, I interviewed Lynn VanBlargan, Licensee via telephone. Ms. VanBlargan called me to inform me of the incident and reported that the bus that transports Resident A to her day program usually arrives at about 7:30a.m. but on this date, 09/16/2026, they arrived early and took Resident A to the bus before she was able to administer Resident A's morning medications.

On 09/17/2026, I received an IR (Incident Report) from Ms. VanBlargan. The IR was dated 09/16/2026 at 7:00a.m. and documented the following information, '(Resident A) *missed her med pass this morning. Her transportation showed up early and she was not ready and was still naked in her room. I helped her dress, get in her wheelchair and to the dining room as fast as I could. I went to grab (Resident A's) coat for her and come back to give it to her and get her meds. When I returned, she was already taken out of the house. Considering* (Resident A's) *ride continues to come earlier and earlier without notice and doesn't wait for us to finish her care, we will have to start having (*Resident A*) wake up earlier.'* The IR documented that Resident A's legal guardian, Susan Griswald was notified of this incident on 09/16/2026 at 10:00a.m.

On 09/30/2026, I conducted an onsite inspection at Resident A's day program and interviewed Kelly Dahlman, program coordinator and Nathaniel Ebeling, CEO, was in attendance. Ms. Dahlman stated there have been two incidents, one on 08/27/2026 and the other on 09/16/2026 that Resident A came to day program without getting her morning medication. Ms. Dahlman stated on 08/27/2026, Ms. VanBlargan was out of town and the staff that she had at the facility were sleeping on the couch. Resident A stated she got up and left for day program without any of her morning medications. Ms. Dahlman stated on 09/16/2026, the bus arrived early and Resident A did not have time to take her medications prior to leaving the facility for day programming.

On 09/30/2026, I interviewed Resident A in the conference room at the day program. Resident A stated on 08/27/2026, Ms. VanBlargan was out of town and Mr. J.

VanBlargan was there, but he was sleeping on the couch. Resident A stated he was supposed to wake her up, but he did not so she got ready and went to the bus and did not take her morning medication before she went to day program. Resident A stated on 09/16/2026, Ms. VanBlargan was working in the facility, the van came too early to pick her up for day program, and she did not have time to take her morning medications.

On 10/14/2026, I interviewed Monique Collins, APS (Adult Protective Services) Worker via telephone. Ms. Collins stated the incident she is investigating was the incident dated 08/27/2026, the allegation was that staff are not getting up in the morning and giving her medication. Ms. Collins stated Ms. VanBlargan was not working on this date, and Jayce VanBlargan was working. Ms. Collins reported that according to Ms. VanBlargan, Resident A went out of the AFC to the bus on her own prior to getting her medication. Ms. Collins stated this is still an open investigation.

On 10/21/2026, I reviewed Resident A's MAR (medication administration record) for the months of August 2026 and September 2026. Resident A's a.m. (morning) medications are as follows:

- **August 2026:** Lisinopril tab 10MG, take 1 tablet by mouth once daily, Lisinopril tab 5MG, take 1 tablet by mouth once daily, take with 10MG tablet=15MG, Mirabegron Tab 50MG ER, take 1 tablet (50MG) by mouth once daily, Senna Tab 8.6-50MG, take 1 tablet by mouth once daily with Clear lax, Vitamin D3 Tab 25MCG, take 1 tablet by mouth once daily, Carbamazepine Tab 200MG, take 1 tablet (200MG total) by mouth twice daily (once at 8:00a.m. and once at 8:00p.m.), Amlodipine Tab 10MG, take 1 tablet by mouth once daily, Aripiprazole Tab 20MG, take 1 tablet by mouth once daily, Clear lax powder, dissolve 17 grams into 4-8 ounces of liquid and drink once daily for constipation, Isibloom Tab, take 1 tablet by mouth once daily, Methenam Hip Tab 1GM, take 1 tablet (1 gram total) by mouth twice daily, Risperidone Tab 1MG, take 1 tablet by mouth twice daily, Sertraline Tab 10MG, take 1 tablet by mouth twice daily (8:00a.m. and 8:00p.m.).
- **September 2026:** Lisinopril tab 10MG, take 1 tablet by mouth once daily, Lisinopril tab 5MG, take 1 tablet by mouth once daily, take with 10MG tablet=15MG, Mirabegron Tab 50MG ER, take 1 tablet (50MG) by mouth once daily, Senna Tab 8.6-50MG, take 1 tablet by mouth once daily with Clear lax, Vitamin D3 Tab 25MCG, take 1 tablet by mouth once daily, Carbamazepine Tab 200MG, take 1 tablet (200MG total) by mouth twice daily (once at 8:00a.m. and once at 8:00p.m.), Amlodipine Tab 10MG, take 1 tablet by mouth once daily, Aripiprazole Tab 20MG, take 1 tablet by mouth once daily, Clear lax powder, dissolve 17 grams into 4-8 ounces of liquid and drink once daily for constipation, Isibloom Tab, take 1 tablet by mouth once daily, Methenam Hip Tab 1GM, take 1 tablet (1 gram total) by mouth twice daily, Risperidone Tab 1MG, take 1 tablet by mouth twice daily, Sertraline Tab 10MG, take 1 tablet by mouth twice daily (8:00a.m. and 8:00p.m.).

The medications for 8:00a.m. on 08/27/2026 and 09/16/2026 were marked on the MAR as not administered on either date.

On 11/05/2026, I interviewed Ms. VanBlargan via telephone regarding Resident A missing 8:00a.m. medications on 08/27/2026. Ms. VanBlargan stated on 08/27/2026, she (Ms. VanBlargan) was not at the facility and Mr. J. VanBlargan was working. Ms. VanBlargan stated Mr. J. VanBlargan had become ill and was in the bathroom and when Mr. J. VanBlargan came out of the bathroom to administer Resident A's morning medications, the van had come early, and Resident A was already out of the facility and getting into the van. Ms. VanBlargan acknowledged that Resident A did not get her 8:00a.m. medication on the morning of 08/27/2026 in addition to not getting her 8:00a.m. medication on the morning of 09/16/2026.

On 11/05/2026, I interviewed Susan Griswold, legal guardian for Resident A. Ms. Griswold stated she was informed about Resident A not getting morning medications on 08/27/2026 and 09/16/2026 from Ms. VanBlargan.

On 11/10/2026, I conducted an exit conference with Lynn VanBlargan, Licensee Designee. Ms. VanBlargan acknowledged the incident and stated she will review the report and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	The complainant reported on 09/16/2026 Resident A did not get her 8:00a.m. medications. Ms. Dahlman stated there have been two incidents, on 08/27/2026 and 09/16/2026 that Resident A came to day program without morning medications. Resident A reported she did not get her 8:00a.m. medications on 08/27/2026 and 09/16/2026. Ms. VanBlargan acknowledged that on 08/27/2026 and 09/16/2026 Resident A left the AFC home and her 8:00a.m. medication had not been administered. Ms. Collins reported Resident A did not get her morning medications on 08/27/2026.

	Ms. Griswold reported she was notified by Ms. VanBlargan that Resident A did not get 8:00a.m. medications on 08/27/2026 and 09/16/2026. Based on investigative findings, Resident A's 8:00a.m. medications were not administered upon leaving the facility on 08/27/2026 and 09/16/2026 for day programming and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 09/30/2026, I conducted an onsite inspection at Resident A's day program and interviewed Kelly Dahlman, program coordinator, and Nathaniel Ebeling, CEO, was in attendance. Ms. Dahlman stated Resident A arrived at day programming on 08/27/2026 with BM (bowel movement) on her and that Resident A reported staff at the facility do not assist her with toileting.

On 09/30/2026, I interviewed Resident A in the conference room at the day program. Resident A stated she can toilet herself and does not rely on staff at the facility for assistance.

On 10/14/2026, I interviewed Monique Collins, APS (Adult Protective Services) Worker via telephone. Ms. Collins stated she received an APS complaint on 08/28/2026 and it included that Resident A presented (to her day program) with feces on her bottom. Ms. Collins stated Resident A informed her that she toilets herself and is capable of toileting herself. Ms. Collins stated Resident A's legal guardian had been notified of the concern that Resident A arrived at her day program on 08/27/2026 with feces on her.

On 10/21/2026, I reviewed Resident A's assessment plan for AFC residents. The assessment plan is dated 01/02/2026, signed by Ms. VanBlargan and Ms. Griswold. The assessment plan documented that Resident A requires assistance with toileting and explains, '*self-toilets at this time but needs hygiene assistance.*'

On 10/21/2026, I interviewed Ms. VanBlargan via telephone. Ms. VanBlargan stated she was unaware of this incident and stated she was never notified about this and unaware that on 08/27/2026, Resident A arrived at her day program with feces on her.

On 11/05/2026, I interviewed Ms. Griswold via telephone. Ms. Griswold stated she was aware of this incident and reported either Ms. Dahlman or Resident A's Health West case manager, Joanna Harrington informed her about it. Ms. Griswold stated she (Ms. Griswold) had never seen Resident A with BM on her but that Resident A

cannot wipe herself, that Resident A tries her best, but she cannot adequately keep herself clean and requires staff assistance with toileting.

On 11/10/2026, I conducted an exit conference with Lynn VanBlargan, Licensee Designee. Ms. VanBlargan stated she will review the report and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on investigative findings, Resident A's assessment plan documented that Resident A requires hygiene assistance after toileting but on 08/27/2026, Resident A presented at her day program with fecal material on her. Therefore, 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.

Elizabeth Elliott

11/10/2026

Elizabeth Elliott Date
Licensing Consultant

Approved By:

Jay Calewarts

11/10/2026

Jay Calewarts Date
Acting Area Manager