



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 11, 2026

Angela Hall
Hallstrom Castle Assisted Living, LLC
5638 Holton Rd
Twin Lake, MI 49457

RE: License #:	AL610395597
Investigation #:	2026A0356051
	Hallstrom Castle Assisted Living

Dear Ms. Hall:

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 #:	AL610395597
Investigation #:	2026A0356051
Complaint Receipt Date:	07/16/2026
Investigation Initiation Date:	07/17/2026
Report Due Date:	09/14/2026
Licensee Name:	Hallstrom Castle Assisted Living, LLC
Licensee Address:	5638 Holton Rd Twin Lake, MI 49457
Licensee Telephone #:	(231) 828-4664
Administrator:	Angela Hall
Licensee Designee:	Angela Hall
Name of Facility:	Hallstrom Castle Assisted Living
Facility Address:	5638 Holton Rd Twin Lake, MI 49457
Facility Telephone #:	(231) 828-4664
Original Issuance Date:	03/09/2020
License Status:	REGULAR
Effective Date:	09/09/2024
Expiration Date:	09/08/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The temperature in the facility is too hot.	No
The food served at the facility is substandard and not what is depicted on the menu.	Yes

III. METHODOLOGY

07/16/2026	Special Investigation Intake 2026A0356051
07/17/2026	Special Investigation Initiated - On Site
07/17/2026	Contact - Face to Face DCW's Tonia Dykes, Kim Dekker, Kayla Santillanes, Resident's A-M, physical plant inspection.
07/17/2026	Contact-Document Received Menu, meals
08/20/2026	Contact-Face to Face Meals, temperature
08/26/2026	Contact-Document Received Facility documents
09/03/2026	Contact-Face to Face Review facility documents
09/11/2026	Exit conference-Angela Hall, Licensee Designee.

ALLEGATION: The temperature in the facility is too hot.

INVESTIGATION: On 07/16/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that on 07/15/2026, the temperature in the facility was 83 degrees even though the thermostat was set to 68. The complainant reported the thermostats throughout the facility all read 82 degrees up to 84 degrees and residents had to be in their "undies" to stay cool. The complainant reported that fans were not provided for each resident and staff reported only one of the two air conditioning units were functioning and it had been that way all summer. The

complainant reported that this is the second heat wave and it was the same way the first time there was a heat wave.

On 07/17/2026, I conducted an unannounced inspection at the facility. The temperature on this date was 86 degrees Fahrenheit and the temperature on 07/16/2026 was 88 degrees Fahrenheit. I observed the thermostats in the main hallways of the facility. One read 78 degrees and the other read 79 degrees. There was central air flowing through the two hallways and a large industrial fan at the end of the hallway near the kitchen and dining room blowing down the hallways. I inspected rooms in the facility. There were 2 empty rooms where there were no residents in care. Those rooms did not have fans and the rooms were warm. Out of the 18 rooms in the facility with residents in care, 15 of the rooms had at least one fan. One of the rooms had two fans circulating the air in the room.

On 07/17/2026, I interviewed Residents C, D, E, F, G & H individually in their rooms. Resident C does not have a fan in her room and said it is warm in her room but "it's not bad" and it is not hot to her. Resident D does not have a fan in his room and stated it is not warm to him. Resident D stated it was warmer yesterday (07/16/2026) but that "today was ok." Resident E had a fan in her room and stated the temperature "feels fine" in her room and before today the temperature was fine. Resident F has a fan in his room and stated, it is not hot to him, "it's fine, I like it." Resident G has a fan on and stated, "yea, it's a little warm" but that her oxygen machine always makes her room warmer. Resident H has two fans in his room and stated, "it has been warmer than usual but it's not bad, I'm not complaining." I sat in Resident H's room for a while and the temperature was acceptable on this date. All the residents interviewed were dressed appropriately for the warm weather.

Residents A, B, I, J, K, L, M were not interviewed because they were either out of their rooms, out of the facility or sleeping. All the residents observed at the facility on this date were dressed appropriately for the warm weather.

On 07/17/2026, I interviewed DCW's (direct care workers) Tonia Dykes and Kim Dekker at the facility. Ms. Dykes and Ms. Dekker stated it was warmer in the facility on 07/16/2026 than it was on this date. Ms. Dykes and Ms. Dekker stated most of the resident rooms have fans. The central air cools the hallways and there is a fan at the end of the hallways blowing down each hallway. Ms. Dykes and Ms. Dekker stated when moving around as much as they do providing care to the residents, it can get warm.

On 07/17/2026, I observed two central air conditioning units out the back door of the facility and both were on and running. There were two other central air conditioning units, one located out the back door of the facility and one on the side of the building. Those two units cool the upper level of the building that are staff offices and storage and do not house any residents. One of those units is working and the other is currently not working.

On 09/03/2026, I reviewed resident assessment plans and health care appraisals (HCA). Resident M's HCA documented 'avoid extreme temperatures,' in the area entitled, 'susceptibility to hyper/hypothermia & related limitations.' The remainder of the HCA's reviewed did not have any information documented re: susceptibility to hyper/hypothermia & related limitations. The resident assessments reviewed documented 'appropriate temperatures are maintained per state regulations.'

On 09/11/2026, I conducted an exit conference with Angela Hall, Licensee Designee via telephone. Ms. Hall stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.653	Room temperature.
	Resident-occupied rooms must be heated at no less than 68 degrees Fahrenheit. While air conditioning is not required, precautions must be taken to prevent prolonged resident exposure to noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations must be based on a resident's health care appraisal and addressed in the resident's assessment plan.
ANALYSIS:	The complainant reported that on 07/15/2026 the temperature in the facility was 83 degrees even though the thermostat was set to 68. The heat is extremely uncomfortable for the residents as well as the visitors and staff. Based on investigative findings, the temperatures inside the facility were elevated and created a warmer than usual setting. The facility had two working central air units running. Air was being circulated by fans in the hallway and in most resident rooms. The temperature of the facility did not exceed the parameters set in the applicable rule and therefore, a violation of this rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The food served at the facility is substandard and not what is depicted on the menu.

INVESTIGATION: On 07/16/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported the residents are fed "crap food" that is not what is depicted on the menu.

On 07/17/2026, I conducted an unannounced inspection at the facility and interviewed Kayla Santillanes in the kitchen at the facility. Ms. Santillanes stated she is the facility cook and follows the menu if they have all the ingredients to make the meals documented on the menus. Ms. Santillanes stated residents are fed breakfast, lunch, dinner and a snack and if they do not have all the ingredients to make the meals, substitutions are made. Ms. Santillanes stated residents can choose an alternative to what is being served which is usually a sandwich. There was no substitution document for review.

On 07/17/2026, I was at the facility as dinner was being cleaned up. I observed the meal on this date was pizza, garlic bread and mashed potatoes. The menu documented pizza for dinner, a side salad and garlic bread.

On 07/17/2026, I interviewed Resident D who stated the food at the facility is "ok, but it is not enough, got a sandwich today with no chips." Resident G stated the food is "crappy" and that she orders other food from Gordon Food Service that she can have made such as "frozen dinners, pot pies, and chili in a can" because she does not like the food served at the facility. Resident H stated on 07/16/2026, they had pepperoni pizza and cold mashed potatoes, and he took the pepperoni off the bread because he did not like pepperoni.

On 07/17/2026, I observed a picture from two different residents of the dinner dated 07/16/2026 at 4:06p.m. and it showed two very small pieces of French bread with a bit of red sauce, two pepperonis on each piece, a small piece of garlic bread and a large serving of mashed potatoes. The mashed potatoes appeared very dry, flaky and almost resembled chunks of cauliflower. The menu documented dinner for 07/16/2026 was supposed to be homemade alfredo, sausage broccoli tortellini.

On 07/17/2026, I interviewed DCW's (direct care workers) Tonia Dykes and Kim Dekker at the facility. Ms. Dykes and Ms. Dekker stated the residents are served breakfast, lunch, dinner and a snack and if the residents choose something else besides what is served for the meal, there are alternatives such as a sandwich. Ms. Dykes and Ms. Dekker acknowledged substitute meals are served on occasion instead of what is on the menu, and residents always get 3 meals a day and a snack.

On 07/17/2026, I inspected the kitchen and observed food in the commercial size refrigerator that consisted of milk, salsa, biscuits, ham, pepperoni, cucumbers, pickles, condiments, peas, chicken, and gravy. I observed food in the commercial size freezer that consisted of cheese tortellini, ham, bread, bacon, frozen bananas, Red Baron pizza, banquet meals, dinner rolls, corn, and ice cream. I observed the pantry storage racks and there were cookies, crackers, stuffing, large cans of green beans, mashed potatoes, diced tomatoes, packaged rice, cream of mushroom soup, Manwich (sloppy joes), ranch, barbeque sauce, pancake mix and boxes of Jello.

On 08/20/2026, I conducted an unannounced inspection and observed dinner which was sloppy joes, chips and watermelon, the menu showed dinner as fried rice with chicken and mixed vegetables. The whiteboard in the dining room showed the changes made for dinner from fried rice to sloppy joes. There was also a document in the kitchen to show the changes made to the menu.

On 08/26/2026, I reviewed the weight records for Resident's A-P, I did not see any large fluctuations in any of the resident weights either gaining or losing.

On 09/11/2026, I conducted an exit conference with Angela Hall, Licensee Designee via telephone. Ms. Hall stated the changes made to the menus are documented and should have been made available. Ms. Hall acknowledged that a substitution of mashed potatoes with pizza is unusual and if the residents want something else to eat, they are always allowed an alternative meal such as a sandwich. Ms. Hall stated they have added more fruits and vegetables to their menu and increasing staffs' awareness of quality substitutions and documentation.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.
ANALYSIS:	The complainant reported the residents are fed substandard food and it is not what is depicted on the menu. Based on investigative findings, there is evidence to show that the meals on the menu were substituted with other items that were not adequate and the substitutions were not documented. 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.



09/11/2026

Elizabeth Elliott, Licensing Consultant

Date

Approved By:

A handwritten signature in blue ink, appearing to read "Jerry Hendrick".

09/11/2026

Jerry Hendrick, Area Manager

Date