GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 8, 2026

Craig Rostoni
Tomlinson Assisted Living LLC
7884 North Road
Burtchville, MI 48059

RE: License #: AM740381292
Investigation #: 2026A0580007
Tomlinson Assisted Living

Dear Craig Rostoni:

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) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM740381292
Investigation #:	2026A0580007
Complaint Receipt Date:	11/20/2025
Investigation Initiation Date:	11/24/2025
Report Due Date:	01/19/2026
Licensee Name:	Tomlinson Assisted Living LLC
Licensee Address:	7884 North Road Burtchville, MI 48059
Licensee Telephone #:	(810) 488-5927
Administrator:	Michelle Rostoni
Licensee Designee:	Craig Rostoni
Name of Facility:	Tomlinson Assisted Living
Facility Address:	6223 Wildcat Road Grant, MI 48032
Facility Telephone #:	(810) 327-2025
Original Issuance Date:	10/03/2017
License Status:	REGULAR
Effective Date:	04/03/2024
Expiration Date:	04/02/2026
Capacity:	11
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A went missing and was found around dawn in a nearby field, barefoot and covered in mud, in freezing weather.	Yes

III. METHODOLOGY

11/20/2025	Special Investigation Intake 2026A0580007
11/20/2025	APS Referral Opened by APS for investigation.
11/20/2025	Contact - Document Received Incident Report received.
11/24/2025	Special Investigation Initiated - Telephone Call to Joseph Linets, APS, St. Clair County.
12/04/2025	Inspection Completed On-site Unannounced onsite.
12/04/2025	Contact - Face to Face Interview with Resident A.
12/04/2025	Contact - Document Received Documents received while onsite.
12/15/2025	Contact - Telephone call made Call to Direct Staff, Joselyn Crawford.
12/15/2025	Contact - Telephone call made Call to Direct Staff, Laura Krstevich.
12/22/2025	Contact - Telephone call made Call to Relative A.
01/07/2026	Contact - Document Received Copy of police report received.

01/07/2026	Exit Conference Exit Conference with LD Rostoni.
01/08/2026	Contact - Telephone call made Call to HM, Samantha Brown.

ALLEGATION:

Resident A went missing and was found around dawn in a nearby field, barefoot and covered in mud, in freezing weather.

INVESTIGATION:

On 11/20/2025, I received a complaint via LARA-BCHS-Complaints. This complaint was opened by Adult Protective Services (APS) for investigation.

On 11/24/2025, I spoke with Joseph Linert, assigned APS Investigator in St. Clair County. Investigator Linert stated that during the 6am shift change 11/14/2025, 3rd shift Staff member Laura Krstevich turned off the alarm to take out the trash and to allow 1st shift Staff, Joslyn Crawford to enter the home. Upon locking the door and turning the alarm at 5:58am back on, it continued to sound, indicating that a door in the home is still ajar. After searching for why the alarm continued to sound, Staff Crawford discovered that the back door was ajar and Resident A was not in her room. Staff Crawford and Staff Krstevich (who was still on the property), began to search for Resident A, and contacted the owner. 911 was called at 6:07am. Resident A was found at 6:33am. Investigator Linert added that Resident A does try to elope. Resident A has a bed alarm, however, Staff at the home admitted that it was turned off because the sound scares Resident A. Investigator Linert added that he does not believe that the Staff were purposely neglectful, however, he will be substantiating Staff Krstevich for neglect. Investigator Linert stated that in his plan developed with the facility, they agreed to keep both alarms on at all times.

On 11/20/2025, I received a copy of the Incident Report (IR) dated 11/14/2025. The report states that on 11/14/2025, at 5:58am, Staff Crawford relieved Staff Krstevich. When she turned on the alarm it was still going off. Staff Crawford checked the resident rooms and discovered Resident A was not in the house. Staff Crawford contacted Home Manager (HM) Samantha Brown at 6:06am. Owner, Craig Rostoni contacted 911 at 6:08am. After searching, Resident A was found on her knees, next to the house, right near the field. Resident A's body was still warm. Resident A was brought inside and EMS took her to the hospital. Resident A checked out okay. Staff actions included contacting 911, Relative A, Guardian A, sending Resident A to the hospital and

informing Resident A's current physician. As a corrective measure, Staff have been instructed that the alarm is to remain on at all times, no matter what.

On 12/04/2025, I conducted an unannounced onsite at Tomlinson AFC. Contact was made with HM Brown. HM Brown reiterated the events that led to Resident A's elopement per the incident report written on 11/14/2025. HM Brown stated that Relative A accompanied Resident A to the hospital. Resident A checked out fine and returned to the AFC the same day. Resident A was provided with a bed alarm a few months back, due to being a fall risk, adding that she has a lot of anxiety. Admittedly the alarm was turned off because Resident A does not like the noise. Staff have been instructed that the alarms are to remain on at all times, no matter what. Since the elopement, Resident A has been prescribed with Zanax and is sleeping a lot better at night. Resident A is also on hospice and receives care provided by Harmony Cares. Harmony Cares also conducted a follow-up visit.

On 12/04/2025, while onsite I received a copy of the AFC Assessment Plan for Resident A, the McLaren Hospital Discharge Summary as well as the Harmony Cares Hospice updated service plan.

The AFC Assessment Plan indicates that Resident A is able to move independently while in the community. Resident A has attempted elopements in the past; however, this is the first time that Resident A had gotten out of the AFC. Resident A is diagnosed with COPD, Dementia, GERD, Depression and Sleep Apnea.

The McLaren Port Huron Hospital Discharge Summary indicates that Resident A was seen and treated on 11/14/2025 after having escaped from her AFC home, found in a field, crawling in mud, for an estimated hour. Resident A denied any pain and reported feeling cold. Lab work returned within normal range. A review of all systems are negative. Resident A was discharged back to the home on the same day.

The Harmony Cares visit summary indicates that Resident A was seen on 11/17/2025. Updates to the Harmony Cares care plan indicate that due to Resident A's fall/elopement risk, she should continue to use her walker. The AFC home is to turn alarms on all exits, at all times. Caregivers are also instructed to ensure that Resident A keeps alarm bedside at all times to avoid elopement. Resident A was also prescribed Alprazolam (Xanax) 0.5mg tablet, to be taken 3 times a day for anxiety.

On 12/04/2025, while onsite, I attempted to interview Resident A. Resident A was adequately groomed and dressed while sitting at the kitchen table drinking coffee. Resident A did not appear to be oriented to place or time. Resident A responded. "yes" when asked if she'd gotten outside of the AFC home. Resident A stated that the Staff takes good care of her.

Also observed in the kitchen area were 2 Staff, and 2 additional residents that were sitting at the table. All 3 residents were adequately dressed and groomed. No concerns regarding their care were noted. They appeared to be receiving proper care.

On 12/15/2025, I interviewed Direct Staff, Joslyn Crawford stated that on the day in question, she was scheduled to begin working at 6am, however, she arrived around 5:50am. Once she got inside, Staff Ksrtivich provided her with resident updates then left for the day. Staff Crawford stated that when she closed the door and turned the alarm back on, it continued to sound. Upon doing room checks she discovered that Resident A was not in her room. Staff Crawford informed Staff Krstevich, who was still in the parking lot, of what occurred, so they both began looking for Resident A. HM Brown and 911 were called. Staff Crawford stated that Resident A does have a bed alarm, which sometimes works and sometimes doesn't.

On 12/15/2025, I interviewed Direct Staff, Laura Krstivich. Staff Krstevich stated that on the day in question, she'd turned off the alarm to take out the trash. Staff Krstevich stated that she did not realize that Resident A had gotten out of the facility. Staff Krstevich stated that she and her co-worker began looking for Resident A. Staff Crawford called HM Brown. Resident A was found by the owner, Craig Rostini. Staff Krstevich stated that Resident A has tried to elope previously, however, she was redirected. Staff Krstevich stated that Resident A does have a bed alarm, however it was not on at the time of her elopement because it scares her. Staff Krstevich added that she feels awful about the situation.

On 12/22/2025, I interviewed Relative A. Relative A stated that the AFC home immediately called her when Resident A was missing. Relative A stated that she was told that Resident A had gotten out during a shift change. Once Staff rounds were made it was discovered that Resident A was not in her room. Relative A stated that she accompanied Resident A to the hospital. Physically, Resident A checked out fine and returned to the home. Relative A added that she is satisfied with the preventative measures, i.e., always keeping Resident A's bed monitor on, as well as the medication change. Relative A added that Staff at the home have been kind-hearted and caring, adding that they always communicate and there have been no prior concerns regarding Resident A's care.

On 01/07/2026, I obtained a copy of the St. Clair County Police Report dated 11/14/2025. The report indicates that on 11/14/2025, at 6:21am, a missing person's complaint was received. AFC resident left sometime in the night. Dispatched to attempt to locate. She was located by an employee prior to officer arrival. EMS dispatched to check her condition. This report was completed by TSWESTPHALM (03265).

On 01/07/2026, I spoke with Licensee Designee, Craig Rostoni regarding the preventative measures that have been put in place to prevent Resident A from eloping again. LD Rostoni agreed to include these measures in the corrective action plan.

On 01/08/2025, I spoke with HM Samantha Brown regarding ensuring that the AFC Assessment plans for the residents are updated accordingly.

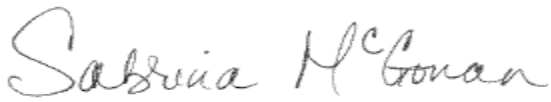
APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	It was alleged that Resident A went missing and was found around dawn in a nearby field, barefoot and covered in mud, in freezing weather. St. Clair County APS Investigator, Joseph Linert, stated that he does not believe that the Staff were purposely neglectful, however, he will be substantiating Staff Krstevich for neglect. The Incident Report (IR) dated 11/14/2025 was reviewed. The St. Clair County Police Report dated 11/14/2025 was reviewed. Resident A is diagnosed with dementia. Resident A had attempted elopement in the past. The McLaren Port Huron Hospital Discharge Summary dated 11/14/2025 states that Resident A was seen and treated after having escaped from her AFC home. Resident A denied any pain and reported feeling cold. Lab work returned within normal range. A review of all systems are negative. Resident A was discharged back to the home on the same day. The Harmony Cares Hospice visit summary indicates that Resident A was seen on 11/17/2025. Updates to the Harmony Cares care plan indicate that due to Resident A's fall/elopement risk, she should continue to use her walker. The AFC home is to turn alarms on all exits, at all times. Caregivers are also instructed to ensure that Resident A keeps alarm bedside at all times to avoid elopement. Resident A was also prescribed Alprazolam (Xanax) 0.5mg tablet, to be taken 3 times a day for anxiety. Home Manager, Brown stated that Resident A was provided with a bed alarm a few months back. Staff have been instructed that the home and bed alarms are to remain on at all times. I attempted to interview Resident A. Resident A did not appear to be oriented to place or time. Resident A responded. "yes" when asked if she'd gotten outside of the AFC home. Resident A stated that the Staff takes good care of her.

	Direct Staff, Joslyn Crawford, stated that upon doing room checks she discovered that Resident A was not in her room. Staff Crawford informed Staff Krstevich, who was still in the parking lot, of what occurred, so they both began looking for Resident A. Administrator Brown and 911 were called. Staff Crawford stated that Resident A does have a bed alarm, which sometimes works and sometimes doesn't. Direct Staff, Laura Krstivich, stated that on the day in question, she'd turned off the alarm to take out the trash. Staff Krstevich stated that she did not realize that Resident A had gotten out of the facility. Staff Krstevich stated that Resident A does have a bed alarm, however it was not on at the time of her elopement because it scares her. Relative A stated that the AFC home immediately called her when Resident A was missing. Relative A adds that she is satisfied with the preventative measures, i.e., always keeping Resident A's bed monitor on, as well as the medication change. Relative A added that Staff at the home have been kind-hearted and caring, adding that they always communicate and there have been no prior concerns regarding Resident A's care. Based upon my investigation, which consisted of interviews with facility Staff members, Resident A, Relative A, and APS Investigator Joseph Linert, as well as a review of relevant facility documents pertinent to the allegation, there is evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/07/2026, I conducted an exit conference with Licensee Designee Rostoni. LD Rostoni was informed of the findings of the investigation.

IV. RECOMMENDATION

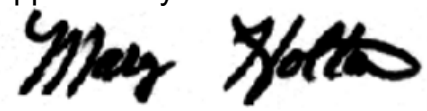
Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.



January 8, 2026

Sabrina McGowan — Date
Licensing Consultant

Approved By:



January 8, 2026

Mary E. Holton — Date
Area Manager