GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 28, 2026

Jamie Saturnino
Group Living Facility Inc
G5095 Van Slyke Rd
Flint, MI 48507

RE: License #:	AL250006953
Investigation #:	2026A1039046
	Group Living Facility Inc

Dear Jamie Saturnino:

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,



Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250006953
Investigation #:	2026A1039046
Complaint Receipt Date:	08/06/2026
Investigation Initiation Date:	08/06/2026
Report Due Date:	10/05/2026
Licensee Name:	Group Living Facility Inc
Licensee Address:	G5095 Van Slyke Rd Flint, MI 48507
Licensee Telephone #:	(810) 767-5858
Administrator:	Jamie Saturnino
Licensee Designee:	Acting - Jamie Saturnino
Name of Facility:	Group Living Facility Inc
Facility Address:	G5095 Van Slyke Road Flint, MI 48507
Facility Telephone #:	(810) 234-9461
Original Issuance Date:	03/15/1976
License Status:	REGULAR
Effective Date:	11/21/2024
Expiration Date:	11/20/2026
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 7/31/2026, Direct Care Worker Tamara Pesta left medication unattended, and a resident who the medication was not intended for, took the medication and became ill.	Yes

III. METHODOLOGY

08/06/2026	Special Investigation Intake 2026A1039046
08/06/2026	Special Investigation Initiated - Letter Email to GHS ORR Kim Nguyen concerning complaint.
08/06/2026	Contact - Document Sent ORR Nguyen stated that she is investigating complaint.
08/06/2026	APS Referral Completed via online referral.
08/25/2026	Inspection Completed On-site Interviewed LD, DCW, Resident A and Resident B.
08/25/2026	Contact - Telephone call made Attempted phone call with DCW Pesta. No answer left message.
09/01/2026	Contact - Telephone call made Attempted phone call with DCW Pesta. No answer left message.
09/24/2026	Contact - Telephone call made Attempted phone call with DCW Pesta. No answer left message.
09/25/2026	Contact - Telephone call made Attempted phone call with LD. No answer emailed LD regarding complaint.
09/25/2026	Exit Conference Completed with LD.
09/25/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

On 7/31/2026, Direct Care Worker Tamara Pesta left medication unattended, and a resident who the medication was not intended for, took the medication and became ill.

INVESTIGATION:

On 08/06/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that On 7/31/2026, Direct Care Worker Tamara Pesta left medication unattended to assist a resident who had an accident, and another resident who the medication was not intended for, took the medication and got sick.

On 08/06/2026, Genesee Health Systems Office of Recipient Rights (ORR) Worker Kim Nguyen emailed me. ORR Nguyen informed me that she investigated the complaint and would be substantiating.

On 08/25/2026, I completed an unannounced onsite investigation at Group Living Home concerning the allegations. I interviewed the following people: Licensee Designee Jamie Saturnino, Direct Care Worker Samantha Morris, Resident A and Resident B.

On 08/25/2026, I completed an interview with Licensee Designee (LD) Jamie Saturnino concerning the allegations. LD Saturnino stated she was familiar with the allegations and they were true. LD Saturnino stated that on 07/31/2026, Direct Care Worker (DCW) Tamara Pesta was administering medication to a resident when another resident had an accident. DCW Pesta set the medication down on the counter to assist the resident who had the accident. When DCW Pesta left to go assist the other resident, at that time Resident A came and took the medication that was left on the counter and took the other resident's medication and became ill. LD Saturnino stated that DCW Pesta notified on-call supervision and told them what happened. LD Saturnino stated that the family, Office of Recipient Rights and Poison Control were notified. LD Saturnino stated Resident A was monitored but he appeared lethargic and was drooling so he was taken to McLaren Hospital, where he was kept until 08/02/2026. LD Saturnino stated Resident A's employment was terminated as this was her second offense regarding medication administration. LD Saturnino stated that there have been no further issues regarding medication administration and that staff have taken refresher training for medication administration.

I reviewed the medication room and the Medication Administration Records (MARs) for three residents. The medication room is secure with locks, and the medication is locked securely. The MARs were up to date and the records appeared accurate and up to date. I did not have any concerns regarding the medication room or MARs.

I reviewed an Incident Report (IR) dated 07/31/2026. The IR notes that Resident A took another resident's medication and the on call manager was notified. The manager called instructed staff to check Resident A's health, monitor him for the next 12 hours for health and wellbeing and call poison control. Resident A appeared sedated and was drooling. Resident A was transported to McLaren Hospital for treatment.

On 08/25/2026, I completed an interview with Direct Care Worker (DCW) Samantha Morris concerning the allegations. DCW Morris stated that she was aware of the allegations and that they were true. DCW Morris stated that she was not working that day, but that DCW Pesta was terminated after the incident occurred. DCW Morris stated that DCW Pesta was a newer staff but was trained to administer medication. DCW Morris stated that all the staff have been trained to administer medication and that this was the first issue that she was aware of where something like this happened. DCW Morris stated that management went over the medication administration training again after this incident as a refresher. DCW Morris stated that there have been no other issues since this incident occurred. DCW Morris stated that the resident that was involved was sent to the hospital but has since returned and there are no reported health issues as a result of taking someone else's medication.

On 08/25/2026, I completed an interview with Resident A. Resident A was sitting at the dining room table at the time of our interview. Resident A appeared neat and clean and was able to communicate in small sentences. Resident A is diagnosed with Intellectual disability. Resident A stated that he does not remember the incident and does not remember taking the medication. Resident A stated that the staff do a good job and he likes it in the home and does not want to leave. Resident A stated that he gets his medication every morning and that he goes to the staff office and they give it to him there. Resident A stated that he did not want to talk anymore and wanted to go back to his room.

On 08/25/2026, I completed an interview with Resident B. Resident B was sitting at the dining room table at the time of our interview. Resident B appeared neat and clean and was able to communicate. Resident B stated that she was not aware of the allegations. Resident B stated that she has been at the home a long time and has never received the wrong medication. Resident B stated that the staff do a wonderful job of taking care of the residents. Resident B stated that she gets her medication in the morning at the staff office and the staff give her water to take with her medication. Resident B stated that she does not have any concerns about the staff.

I was unable to interview Direct Care Worker (DCW) Tamara Pesta. I attempted to call DCW Pesta on 08/25/2026, 09/01/2026 and 09/24/2026, with no success. I left my contact information for DCW Pesta.

On 09/25/2026, I completed an exit conference with Acting Licensee Designee (LD) Jamie Saturnino. I informed LD Saturnino of the results of my investigation. LD Saturnino stated that she did not have any questions and would return a corrective action plan as soon as possible.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On 7/31/2026, It was alleged that Direct Care Worker Tamara Pesta left medication unattended, and a resident who the medication was not intended for, took the medication and became ill. I interviewed the Licensee Designee and Direct Care Worker concerning the allegations and they state that the allegations are true. Licensee Designee stated that DCW Pesta left medication unattended and Resident A took the medication and became ill. Licensee Designee stated that the family, ORR and poison control were notified of the incident. Licensee Designee stated that DCW Pesta has been terminated from employment. Licensee Designee stated that Resident A was taken to the hospital and as he was lethargic and drooling after he took the medication. Licensee Designee stated that Resident A was in the hospital from 07/31/2026 to 08/02/2026 and was returned to the home and has not displayed any lasting effects from taking the medication. Genesee Health Systems Office of Recipient Rights (ORR) Worker Kim Nguyen investigated the complaint. ORR Nguyen substantiated the complaint. Resident A did not remember the incident but stated that he likes the home and does not want to leave. Resident A stated that the staff administer his medication in the mornings and that the staff do a good job at the home. Upon completion of my investigation, it has been determined that there is enough evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in licensure status.



09/28/2026

Martin Gonzales Licensing Consultant	Date

Approved By:



09/28/2026

Mary E. Holton Area Manager	Date