GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2026

Lawrence Ragnone
Grainhouse Grove, LLC
3520 Davenport Avenue
Saginaw, MI 48602

RE: License #: AL130419860
Investigation #: 2026A1032037
Grainhouse Grove MC

Dear Lawrence Ragnone:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL130419860
Investigation #:	2026A1032037
Complaint Receipt Date:	05/05/2026
Investigation Initiation Date:	05/07/2026
Report Due Date:	07/04/2026
Licensee Name:	Grainhouse Grove, LLC
Licensee Address:	3520 Davenport Avenue, Saginaw, MI 48602
Licensee Telephone #:	(989) 293-4621
Administrator:	Lawrence Ragnone
Licensee Designee:	Lawrence Ragnone
Name of Facility:	Grainhouse Grove MC
Facility Address:	197 Lois Drive, Battle Creek, MI 49015
Facility Telephone #:	(989) 293-4621
Original Issuance Date:	03/06/2026
License Status:	TEMPORARY
Effective Date:	03/06/2026
Expiration Date:	09/05/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is improperly staffed.	No
Food service is subpar.	No
Medication errors are not being reported.	No

III. METHODOLOGY

05/05/2026	Special Investigation Intake 2026A1032037
05/07/2026	Special Investigation Initiated - Letter
05/07/2026	Contact - Document Received I received incident reports and medication error documentation
05/20/2026	Inspection Completed On-site Interview with Resident A, Administrator Katie Brown and Employee #1
07/09/2026	Exit Conference

ALLEGATION:

The facility is improperly staffed.

INVESTIGATION:

On 5/7/26, I reviewed the staffing pattern for the last four months. There were no issues with the ratio of staff to residents, with a minimum of two on all shifts.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection

	of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	The staffing pattern provided reflected a minimum of two staff per shift. Therefore, no violation was established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Food service is subpar.

INVESTIGATION:

On 5/20/26, I interviewed executive director Katie Brown in the facility. Ms. Brown stated that the facility had recently hired a new food service director. While she denied that the food was subpar, she acknowledged that there had been issues with the prior title holder. During my onsite inspection, I inspected the kitchen area and noted that its condition was sanitary. Chicken, mashed potatoes and a vegetable side were being served for lunch. The menus I observed were of proper consistency.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	According to the menus, the facility was in compliance with the administrative rule. I observed a hearty meal being cooked. I also observed sanitary practices in the kitchen such as hairnets, glove use and clean surfaces. Therefore, I was unable to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medication errors are not being reported.

INVESTIGATION:

On 5/7/26, I reviewed incident reports where residents were given Benadryl per the medication administration record (MAR) instructions, only to discover that the residents were allergic to it.

I interviewed Resident A in the facility. Resident A was not well oriented, providing tangential information that was not relevant to medication management.

I interviewed Employee #1 in the facility. Employee #1 stated that she had not directly witnessed a situation where another employee had given Resident A's medication without supervising him, resulting in Resident A passing the medication to his wife. She stated that she had heard rumors.

Executive director Katie Brown stated that an employee named Quay had given Resident A his medication, saw that he tried to give it to his wife, then re-directed him to take his medication. Ms. Brown stated that at no time was Resident A left unsupervised and that he had taken his medication. Ms. Brown indicated that there was discord between Quay and other employees that had resulted in terminations, due to them discriminating against him.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(f) Contact the resident's licensed health care professional or the appropriately licensed health care professional who prescribed the medication when a medication error occurs.**
ANALYSIS:	There were medication errors that were reported, although there seemed to be a discrepancy between allergy status and instructions in the MAR. Employee #1 had only heard rumors about Quay not supervising Resident A, but Ms. Brown denied that this actually happened. Therefore, there was insufficient evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 7/9/26, I conducted an exit conference with Bridgeway Park Battle Creek licensee designee Marcia Curtiss. Ms. Curtiss had informed me that Grainhouse Grove had been purchased and that a management agreement was in place to operate the facility. I shared my findings and Ms. Curtiss agreed with the conclusions reached.

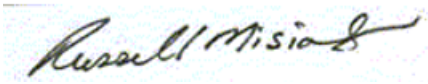
IV. RECOMMENDATION

I recommend no change to the status of this license.

7/15/26

Dwight Forde — Date
Licensing Consultant

Approved By:



7/15/26

Russell B. Misiak — Date
Area Manager