GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2026

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

RE: License #: AL130419730
Investigation #: 2026A1032042
Grainhouse Grove AL

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 #:	AL130419730
Investigation #:	2026A1032042
Complaint Receipt Date:	05/20/2026
Investigation Initiation Date:	06/04/2026
Report Due Date:	07/19/2026
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 AL
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

II. ALLEGATION(S)

	Violation Established?
Inadequate staffing levels led to a decline in Resident A's health.	No

III. METHODOLOGY

05/20/2026	Special Investigation Intake 2026A1032042
06/04/2026	Special Investigation Initiated - Letter
06/09/2026	Contact - Document Sent I requested an incident report from executive director Katie Brown
07/09/2026	Contact - Document Received
07/17/2026	Contact - Telephone call made Call made to Sarah
07/23/2026	Contact - Document Received Incident reports from Marcia Curtiss
07/24/2026	Exit Conference

ALLEGATION:

Inadequate staffing levels led to a decline in Resident A's health.

INVESTIGATION:

On 5/20/26, I received this investigation while conducting an onsite inspection at the facility. At that time, I had established through SIR # 2026A1032037 that the facility had an appropriate staffing pattern.

On 6/9/26, I requested a copy of Resident A's incident report, where she fell and was transported to the hospital.

On 6/19/26, I verified the accuracy of the complaint information with the referral source. I was advised that Grainhouse Grove had been sold to a new entity.

On 7/9/26, I received a copy of the incident report where Resident A tried to walk on her own but fell. The incident report also noted that Resident A had low blood sugar when emergency medical services (EMS) arrived. The report was authored by a Sarah Molina. Bridgeway Park Battle Creek licensee designee Marcia Curtiss provided the report, and advised that there were two members of staff on shift at the facility at that time.

On 7/17/26, I placed a call to an employee, Sarah, but received no response.

On 7/23/26, I received more incident reports from Ms. Curtiss. One report detailed a medication error, where Resident A was given an anti-diarrheal instead of a stool softener. The other incident report detailed an unwitnessed fall in January 2026 where Resident A presumably tried to transfer herself from the bed to a wheelchair and fell. I also received charting notes detailing past issues with low blood sugar, where Resident A did not eat enough, as well as contention between the staff and family members, who had issues with doctors' orders.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service. **(2) Care and services provided to a resident must be designed to maintain or improve a resident's physical and intellectual functioning and independence.**
ANALYSIS:	I had established that the facility staffing levels were appropriate on SIR# 2026A1032037. I reviewed incident reports where Resident A tried to transfer herself and was injured; there were no major medication errors noted. According to facility notes, Resident A's blood sugar issues may have stemmed from poor self-determined eating habits. Therefore, there is insufficient evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 7/24/26, I shared my findings with Bridgeway Park Battle Creek licensee designee Marcia Curtiss.

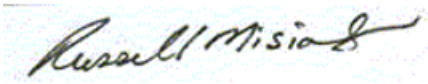
IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

7/31/26

Dwight Forde — Date
Licensing Consultant

Approved By:



8/4/26

Russell B. Misiak — Date
Area Manager