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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

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DIRECTOR

September 15, 2026

Kalamazoo Behavioral Health Hospital (PSYH000058)
C/O Tim Radabaugh
5802 S 9th St
Kalamazoo, MI 49009

SUBJECT: Review of Corrective Action Plan Kalamazoo Behavioral Health Hospital

Dear Tim Radabaugh:

A site visit was conducted on June 11, 2026, due to reports of multiple falls with injury and hospitalizations, at Kalamazoo Behavioral Health Hospital located at 5802 S 9th St, Kalamazoo, MI 49009. Follow-up visits, request for documentation, and access to records were also conducted after the on-site visit.

An investigation was carried out that resulted in multiple findings including:

In review of the multiple falls with injuries and series of patient hospitalizations, patient transfer log was requested, as were incident reports for January through May. Patients were sent to the hospital for evaluation for falls, unresponsiveness, or assault on 43 occasions. For each hospital transfer, incident reports were attempted to be viewed however, many falls with injury and unresponsive patients were not recorded as incidents. Incidents of falls with injury, unexplained injury, and unresponsive patients increased in number in April and May of 2026.

In April 2026, 10 of 26 patients sent to the hospital for evaluation were due to falls with injury, and assault. In May 2026, 14 of 31 patients transferred to the hospital for evaluation were due to falls with injury, unexplained injury, or being found unresponsive. Many patients that experienced falls with injury were not evaluated at the time of fall.

Most falls with injury that required hospital evaluation were not included in incident reports. The facility did not provide a root cause analysis for the large number of falls.

Rounding sheets were also reviewed for patients with emphasis on the time surrounding the day of hospital evaluation and the day prior to hospital evaluation. Each patient reviewed had gaps in 15 minute-ordered rounding of up to 45 minutes. For one patient with 5 minute-ordered rounding, there were significant gaps of up to an hour without viewing the patient, who was noted as a fall risk. This patient later had an unwitnessed fall.

Following the investigation, Kalamazoo Behavioral Health Hospital was found to be non-compliant in multiple areas including:

R 330.1260 *Patient Rights, and the Mental Health Code*
Rule 1260. A hospital shall insure, in written policy and in practice, that individuals receiving services shall be entitled to the rights guaranteed by the act and the rules promulgated thereunder.
The licensee hospital has failed to ensure in practice that individuals receiving services are protected and guaranteed the rights entitled while at the licensed facility.

***MCL 330.1708(2)*, Suitable services; treatment environment; setting; rights;**
Sec. 708 (2) Mental health services shall be provided in a safe, sanitary and humane treatment environment
Due to the large number of falls with injuries, patient to patient assaults and gaps in ordered rounding the facility has failed to demonstrate providing a safe environment to receive mental health services.

***MCL 330.1722*, Protection of recipient form abuse or neglect.**
Sec 722 (1) A recipient of mental health services shall not be subject to abuse or neglect.
Patients were transferred to the hospital on 43 occasions in a five month period. Fifteen of these charts were reviewed. In most cases there was no documentation of injury that led to hospital evaluation. In many cases, ordered rounding had not been conducted or had been missed. Almost half of the hospital evaluations are due to falls, unexplained injury, or noted patient to patient assault. Multiple unwitnessed falls resulted in hospitalization and fractures. The facility has not demonstrated protection of patients from abuse or neglect.

R 330.1276(3), Records
(3) A licensee shall maintain an adequate medical record for every patient in the hospital, which shall include all of the following information:
- *(a) Identification data and consent forms.*
- *(b) History of the patient.*
- *(c) All of the following reports:*
  - *(i) Psychiatric evaluations.*
  - *(ii) Neurological and physical examinations.*
  - *(iii) Other diagnostic procedures and examinations.*
- *(d) Individualized plan of services.*
- *(e) Medical orders.*
- *(f) Observations.*
- *(g) Reports of actions, findings, and conclusions.*
- *(h) Discharge summary.*

Patient records are kept on paper as opposed to an electronic charting system. In one patient chart, consent forms were not signed by the guardian, and only one attempt was made to contact the guardian to obtain consents and provide

information. Patient records lacked nursing notes or assessments on multiple occasions. In most patient records, there was no documentation of falls, assaults, or injuries. In cases where there was documentation, observations of falls and injuries were made after the patient had been evaluated by the Nurse Practitioner or sent to the hospital for acute injury.
There were no incident reports, for many of these occurrences. There was no root cause analysis performed. All charts reviewed lacked at least one of the above-required records.

R 330.1281 Physician responsibility
Rule 1281. (1) Health care of every patient in a psychiatric hospital or a psychiatric unit shall be under the supervision of a physician from the time of admission to discharge.
There is not a physician or psychiatrist available at this facility. There is no record of physicians or psychiatrists seeing patients. Nurse practitioners see patients for medical and psychological needs.

R 330.1281(2) Physician responsibility
(2) The type, duration, and amount of medications and medical treatment shall be ordered by a patient's physician or by a psychiatric hospital physician if the patient's physician is not available.
A patient was admitted to the facility from the emergency department with a documented medical condition requiring a specific diet. This medical condition and diet were not acknowledged by the nurse practitioners providing care and the patient was subsequently hospitalized for complications related to this medical condition.

Kalamazoo Behavioral Health Hospital submitted a corrective action plan on August 13, 2026 that did not meet the requirements of Part 201 of the Public Health Code (MCL 333.20101 through 333.20211), Chapter 1 of the Mental Health Code (MCL 330.1100 through 330.1164), and/or the Michigan Administrative Rules for Licensing of Facilities (R330.1201 through R330.1299), as applicable.

A plan for compliance was not demonstrated for the following:

R 330.1260 *Patient Rights, and the Mental Health Code*
Corrective action plan states standardizing recipient rights practices but relies on patients filing complaints. Patient's rights should be upheld regardless of if a complaint is filed.

MCL 330.1708(2), Suitable services; treatment environment; setting; rights;
Corrective action plan states updating fall risk assessments, implementing fall programs and committees, staff education, and new policies and post event practices.
This corrective action plan does not address the severity of injuries with falls, gaps in ordered rounding, or patient assaults.

MCL 330.1722, Protection of recipient form abuse or neglect.

Corrective action plan includes reporting events, root cause analysis, in-depth review of falls, and education on documentation.
This corrective action plan does not address the current lack of monitoring of patients leading to extensive injury with multiple unwitnessed falls, assaults, or other injuries. The facility did not submit a root cause analysis for any of the 43 incidents under investigation.

R 330.1276(3), Records

Corrective action plan includes daily chart audits with a goal of 90% documentation completion. The corrective action plan also states that the director of clinical services will audit 20 inpatient records per month for appropriateness of treatment plan.
A ninety percent documentation completion rate is not acceptable for a facility with a substantial patient injury rate. Director of clinical services is not a physician or authorized prescriber and cannot determine appropriateness of treatment/medications (MCL 330.1719 and R 330.7158).

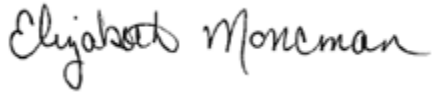
R 330.1281 Physician responsibility

Corrective action plan includes education for providers on documentation and assessments by the director of quality or nursing supervisors.
Corrective action plan does not indicate that the facility plans to obtain a psychiatrist or a physician. There is no indication that patients in this facility are under the supervision of a physician or psychiatrist.

R 330.1281(2) Physician responsibility

Corrective action plan states nursing will review chart and give the provider a dietary referral.
This corrective action plan is not in alignment with the nursing scope of practice ie writing or recommending dietary orders. Under Michigan law, it is the admitting physician's responsibility to review the chart and provide all admission orders. (R 325.45217).

This corrective action plan is not accepted.



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