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ECHRShealth.org

EATON COUNTY HEALTH & REHABILITATION SERVICES

GRIEVANCE/CONCERN POLICY & FORM

INSTRUCTIONS FOR REQUESTING ASSISTANCE FROM STAFF OF EATON COUNTY HEALTH & REHABILITATION SERVICES

We are committed to providing the highest quality of care to patients and residents of our facility. We want to ensure that your voice is heard and that you feel safe, involved, and informed. Therefore, it is the policy of ECHRS to ensure prompt resolution of resident and responsible party grievances. You have the right to file grievances orally, in writing, or anonymously.

If you would like to file a grievance, the contact information for the grievance official for ECHRS is:

Stacey Steiner, HR/Compliance Director
530 W. Beech Street, Charlotte, MI 48813
517-543-2940 extension 2709
ssteiner@echrshealth.org

Below is the secondary grievance official.

Tama Cunningham, Building Services Director
530 W. Beech Street, Charlotte. MI 48813
517-543-2940 extension 2722
tcunningham@echrshealth.org

We encourage you to follow the steps identified below if you have any concerns about your care, treatment by staff, or anything else related to your stay. For general questions, we encourage you to contact the Clinical Mentor on the neighborhood where you or your loved one is staying, if this does not address your question or concern:

Step 1 Tell the *(***staff person on each shift designated to handle complaints)** of your concern. During business hours M-F the person listed above is the person(s) to contact. If it is after hours or weekends, the Victorian Lane nurse will assist with concerns.

Step 2 If you wish, you may complete our Grievance/Concern Form for resolution. Let us know if you need help in completing this form.

Step 3 Submit the form to **Stacey Schultz, Compliance Director (see above contact information).**

Step 4 If not satisfied with the facility's response, complete a request for the Administrator, Martha Richad, to review the investigation findings.

Step 5 If not satisfied with the Administrator's resolution, you may contact the State Ombudsman or the Michigan Department of Community Mental Health, Bureau of Health Systems, to file a formal complaint.

WE WANT YOU TO KNOW THE FOLLOWING

1. We will keep your request as confidential as possible.

2. Our time frame for investigating concerns are:

   (A) Immediately (means as soon as possible, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials when required)- for abuse;

   (B) As Soon As Possible but Within 5 days- for anything that has caused actual harm;

   (C) As Soon As Possible but Within 15 days- for any other concern.

3. We will meet with you and discuss our written response and action plan as soon as possible but no later than 30 days after we receive your request. You have the right to receive a written copy of our response.

4. We will follow-up to ensure your concern has been addressed satisfactorily and use the finding of our investigation as part of our Quality Improvement Program-again keeping your name confidential, if possible.

5. You may contact the **Michigan Department of Community Health, Bureau of Health Systems, at 1-800-882-6006,** to file a complaint, or the **State Ombudsman at 1-866-485-9393 for assistance.**

6. We maintain evidence demonstrating the result of all grievances for a period of no less than three years from the issuance of the grievance decision.

Please give us an opportunity to address your concerns by completing this form if you believe your concerns have not been addressed.

LOCATION OF GRIEVANCE FORMS

There are several locations throughout the building to locate grievance forms, including the front lobby of Eaton Gardens, the back entrance of the building, the Healing Center nurses station, and the facility's website.

INFORMATION ABOUT PERSON WITH CONCERN:

NAME (Please print):

Are you a Patient/Resident of the facility?
☐ YES ☐ NO

If "Yes" what is your Room Number?

If "No" does this relate to a particular Patient or Resident?
☐ YES ☐ NO

Patient/Resident Name:

What is your relationship to the Patient/Resident?

☐ Durable Power of Attorney
☐ Guardian
☐ Employee
☐ Volunteer
☐ Other:

Address (if not Patient/Resident):

Type of Concern:

☐ Family Concern ☐ Patient/Resident ☐ Staff/Volunteer ☐ Quality of Life Survey
☐ Discharge/Exit Survey ☐ Satisfaction Survey ☐ Suggestion Box
☐ Other:

WHAT is your concern about:

WHEN did the problem or incident occur? (DATE):

WHO ELSE KNOWS about the problem or incident? (Include title of facility staff if you know them)

Does this involve staff member(s)? ☐ YES ☐ NO If yes, who?

INFORMATION ABOUT PERSON WITH CONCERN:	
HOW can we address your issues?	
Is this an ongoing problem? ☐ YES ☐ NO If YES, for how long?	Have you contacted us in the past about this concern? ☐ YES ☐ NO If YES, to whom?
Signature (Facility):	Date: