530 West Beech St
Charlotte, MI 48813
p. 517.543.2940 f.517.541.0670
ECHRShealth.org

RESIDENT/RESPONSBILE PARTY GRIEVANCE PROCESS & FORM

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 all grievances. You have the right to file grievances orally, in writing, or anonymously.

If you would like to file a grievance, complete the attached grievance form. Any staff member is able to assist you with completing and submitting to the Grievance Official.

Contact information for the grievance official for ECHRS is:

Alisha McPherson
530 W. Beech Street, Charlotte, MI
48813 517-543-2940 extension 2741
amcpherson@echrshealth.org

We encourage you to follow the steps identified below if you have a concern about your care, treatment by staff, or anything else related to your stay.

Step 1 Tell the Clinical Mentor and or **staff person on each shift designated to handle concerns**. The facility would like to prevent the need for a formal grievance by resolving your concern as soon as possible, but it is still your right to file a formal grievance at any time.

Step 2 If not satisfied with the staff person's response, complete our Grievance Form. Let us know if you need help in completing this form.

Step 3 Submit the form to **Alisha McPherson for reported grievances.**

Step 4 If not satisfied with the Grievance Official's response, you may request that the Administrator review.

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 no 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 no 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);

   (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. The Victorian Lane charge nurse is able to assist with the grievance process after hours and on weekend.

<table>
<tr><th colspan="3">INFORMATION ABOUT PERSON WITH GRIEVANCE:</th></tr>
<tr><td>Name (Please Print):</td><td colspan="2">Are you a Patient/Resident of the facility?
☐ YES ☐ NO
If “Yes” what is your Room Number?</td></tr>
<tr><td>If “No” does this relate to a particular Patient or Resident?
☐ YES ☐ NO

Patient/Resident Name:</td><td colspan="2">What is your relationship to the Patient/Resident?

☐ Durable Power of Attorney
☐ Guardian
☐ Employee
☐ Volunteer
☐ Other:</td></tr>
<tr><td colspan="3">Contact Information (if not Patient/Resident):</td></tr>
<tr><td colspan="3">WHAT is your grievance about:

WHAT is your suggestion for resolution:</td></tr>
<tr><td>WHEN did the problem or incident occur? (DATE):</td><td colspan="2">WHO ELSE KNOWS about the problem or incident? (Include title of facility staff if you know them)</td></tr>
<tr><td>DOES this involve staff member(s)?
☐ YES ☐ NO

If yes, who?</td><td>IS this an ongoing problem?
☐ YES ☐ NO

If YES, for how long?</td><td>HAVE you contacted us in the past about this grievance?
☐ YES ☐ NO
If YES, to whom?</td></tr>
<tr><td>DATE:</td><td colspan="2">SIGNATURE (Resident/Responsible Party):</td></tr>
</table>

GRIEVANCE OFFICIAL'S RESPONSE AND ACTION TO BE TAKEN:	
SIGNATURE (Grievance Official):	Date:
☐ **I am satisfied** with the Grievance Official's response to my grievance.	
☐ **I am not satisfied** with the response to my grievance. I request the Administrator to review my grievance and provide me with a response.	
SIGNATURE (Resident/Responsible Party):	Date: