



Title Patient Rights and Needs - Complaint and Grievance Resolution	Location ALL Beaumont Health	Functional Area Administration
Policy Owner System Director, Perf Excellen	Document Type Policy	Effective Date 06/20/2016

I. CORPORATE AUTHORITY

Beaumont Health (“BH”) as the corporate parent to William Beaumont Hospital, Botsford General Hospital, and Oakwood Healthcare Inc., (“Subsidiary Hospitals”) establishes the standards for all policies related to the clinical, administrative and financial operations of the Subsidiary Hospitals. The Subsidiary Hospitals, which hold all health facility and agency licenses according to Michigan law, are the covered entities and the providers of health care services under the corporate direction of BH. The Subsidiary Hospitals’ workforces are collectively designated as BH workforce throughout BH policies.

II. PURPOSE AND OBJECTIVE: To assure timely and appropriate follow up to patient Complaints and Grievances consistent with Beaumont Health's philosophy on patients' rights.

III. POLICY STATEMENT: It is the policy of Beaumont Health (BH) to address patient Complaints and Grievances in a timely manner.

IV. DEFINITIONS: The following are definitions of terms and words used in this Policy:

- A. **Complaint:** an issue or problem raised by patient or his/her representative that is promptly resolved by staff present. A Complaint also includes matters brought to the attention of the Service Excellence representative by the patient or his/her representative that, upon Service Excellence Representative contact with the appropriate care unit, is promptly resolved by staff present.
- B. **Grievance:** an issue, Complaint or problem raised by a patient or his/her representative as a formal or informal, written or verbal complaint made to the hospital that:
 - 1. requires the involvement of the Service Excellence Representative that has not been resolved promptly at the complaint level (as noted in IV. A. above);
 - 2. is raised following care delivery;
 - 3. requires follow-up per request of the patient or his/her representative via the Grievance process;
 - 4. involves alleged abuse or neglect;
 - 5. has issues related to hospital compliance with CMS Hospital Conditions of Participation (CoP);
 - 6. requires a written response as requested by the patient or his/her representative.
- C. Billing inquiries are not Grievances. Billing inquiries presented with a patient service or care issue are considered a Grievance if raised within 60 days of the related date of service or care.



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- D. Service Excellence Representative: the person designated to address patient Complaints, issues, problems or Grievances by virtue of a job description or assignment by a facility administrator.

V. PROCEDURE:

- A. **General Information.** Complaints and Grievances may arise in several different ways based upon the individual's clinical condition, and/or the complaining person's request. Complaints are generally thought to include minor complaints regarding, by way of example, food issues, requests for linen changes, requests for housekeeping and requests for an explanation in service delay that might occur. Complaints identified during an episode of care and if promptly resolved by staff present, do not generally arise to a Grievance level assuming the complaining person accepts the response or the resolution. Complaint resolution is an informal process. Staff is encouraged to promptly resolve patient Complaints as a means to better meet patient care and service expectations.
1. **Language Barriers.** Communication with patients and family members will be in a language and manner reasonably likely to be understood by the complaining person.
 2. **Post Discharge/Visit Comments.** Comments regarding care may be received after the episode of care. Communications that clearly indicate no follow up is requested or that only express an opinion on a part of the service delivered (e.g., "the food was bland") do not require this Policy to be implemented. The opinion or comment will, however, be forwarded to the appropriate unit/department manager for informational purposes. Per Centers for Medicare and Medicaid Services (CMS) guidelines, information obtained from patient satisfaction surveys usually do not meet the definition of grievance. If an identified patient writes or attaches a written complaint and requests resolution, then the complaint meets the definition of grievance. If an identified patient writes or attaches a complaint to the survey but has not requested resolution, the hospital must treat this as a grievance if the hospital would usually treat such a complaint as a grievance.
 3. **System Issues.** The presence of systemic complaints or complaints related to unit/department or facility operations may become evident at any point during the review process. These matters should be referred to the appropriate persons or committees for analysis and corrective action.
 4. **Complaint and Grievance Process Notice.** When a patient presents for service (admission, registration, etc.), written information regarding the Grievance process (including who may be contacted to file a Complaint or Grievance) is made available to the patient.
- B. **General Rules On Receiving a Complaint or Grievance.** Complaints and Grievances may be received while the patient is receiving services. Only Grievances (not Complaints) may be received after the completion of the delivery of service. Complaints and Grievances may be communicated in person, by telephone or in writing.

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1. **Confidentiality.** Communications are received and handled in a confidential manner, and occur in a secure private location when possible.
2. **Courtesy.** Complaining persons are treated with courtesy, dignity, respect and sensitivity without fear of reprisal or discrimination.
3. **Unit/Department Level.** Complaints are handled and resolved at the unit/site level whenever possible.
4. **Referrals from Service Excellence Representative.** The Service Excellence representative refers Complaints to the unit/department level whenever appropriate.
5. **Outside Agency References.** The complaining person is informed (or reminded) of the internal Grievance process, thanked for giving the facility the opportunity to address the matter and is reassured of the facility interest to appropriately respond to the matter. Grievances may also be presented to one of the agencies identified below. Upon request, the complaining person is provided the appropriate agency address and telephone number.

Medicare Quality Improvement Organization (KEPRO)
 5201 West Kennedy Boulevard, Suite 900
 Tampa, FL 33609
 Phone: 855.408.8557
 Fax: 844.834.7130

Michigan Department of Health and Human Services (MDHHS)
 Bureau of Health Systems Complaint Investigation Unit
 P.O. Box 30664
 Lansing, MI 48909
 Phone: 1.800.882.6006
 Fax: 517.241.2635

The Joint Commission (TJC) Office of Quality Monitoring
 One Renaissance Blvd.
 Oakbrook Terrace, IL 60181
www.jointcommission.org
 Phone: 800.994.6610

6. **Patient Experience Feedback Completion.** Documentation of complaints and grievances should be made into the online system known as RL Solutions under the Patient Experience Feedback (PEF) section. The person receiving the Complaint initiates the PEF online process. The person resolving the Complaint completes the online PEF process.



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C. Processing the Receipt of a Complaint.

1. Anyone can receive a Complaint. Complaints are referred to the appropriate unit/department supervisor or, in his/her absence, the Service Excellence representative.
2. A private location is secured whenever feasible to discuss the complaints with the complaining person.
3. If the unit/department supervisor is unable to resolve the Complaint, the matter is referred for assistance to the Service Excellence representative and entered into Patient Experience Feedback (PEF). Administrative referrals are handled by the Service Excellence representative or referred to the appropriate unit/department supervisor.
4. Complaining persons receive a copy of the information explaining how a Complaint may be filed if they have not received one. They are also advised of their right to notify MDHHS, TJC or KEPERO regarding their complaint.
5. Once the complaint is received by the Service Excellence representative, the PEF will be forwarded to the appropriate unit/department supervisor for follow up and resolution.
6. Complaints related to a physician are forwarded to the specific physician or Medical Staff Offices as appropriate for follow up. The Chief of Staff is included as needed. The physician should provide a response of the issue to the Service Excellence representative such that the file on the matter may be closed in the PEF process.
7. The unit/department supervisor routinely investigates, analyzes and, consistent with his/her authority, takes action to respond to the complaint. If the complaining person accepts the response, the matter is considered closed. If the response is not accepted by the complaining person, the unit/department supervisor will offer the Grievance process to the complaining person and the process outlined in Section V.D. should be followed. The Service Excellence representative may be consulted for assistance at this time.
8. The unit/department supervisor initiates the online PEF process within seven (7) business days of the initial contact.
9. The Service Excellence representative tasks the online PEF to the site Legal/Quality representative whenever a claim is anticipated.

D. Processing the Receipt of a Grievance.

1. **Notice of Grievance Process.** If a complaining person is not satisfied with the response given to a Complaint or the Complaint is not promptly resolved (typically within the shift when the matter was raised), the complaining person is advised that a formal Grievance may be filed with the facility by contacting the Service Excellence representative.
2. **Receipt of Grievance.**
 - a. The unit department/supervisor who receives a Grievance initiates follow up.
 - b. If the unit/department supervisor is unable to resolve the Grievance, the matter is referred for assistance to the Service Excellence representative. Administrative referrals are handled by the Service Excellence representative or referred to the appropriate unit/department supervisor.
 - c. Grievances related to the physician are forwarded to the Division President, hospital Chief of Staff, the Department Chief and the Medical Staff Office as appropriate.

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The Department Chief should forward the response of the Grievance to the Service Excellence representative to close the file on the matter.

- d. A copy of the written Grievance may be retained in the department which received it. The original written Grievance is forwarded to the Service Excellence representative.
 - e. The unit/department supervisor or Service Excellence representative (whoever first receives the complaint) contacts the complaining person to clarify the issues, and confirm receipt of the complaint. The complaining person is verbally advised of the facility process for responding to complaints. Following contact with the complaining person, an acknowledgment letter may be sent to the complaining person by the unit/department supervisor or Service Excellence representative, as appropriate.
 - f. The unit/department supervisor or Service Excellence representative routinely follows up, in writing, with the complaining person within seven (7) days of the initial contact to share a summary of the investigation and proposed resolution. In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital, hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion. Per CMS guidelines, if the grievance will not be resolved, or if the investigation is not or will not be completed within 7 days, the hospital should inform the complaining person that the hospital is still working to resolve the grievance and that the hospital will follow-up with a written response within a stated number of days. Legal may be consulted prior to mailing written communication to the complaining person, as appropriate.
 - g. The unit/department supervisor completes the online PEF process upon resolution of the Grievance (generally within seven [7] days of the initial contact).
 - h. The Service Excellence representative tasks the PEF to Legal whenever a claim (other than reimbursement), is anticipated. If the matter may reasonably involve a significant regulatory issue or quality issue, Quality or Accreditation is tasked.
3. **Unresolved Grievance.** Grievance resolution shall be initiated by the Service Excellence representative. If the event resolution is not achieved through the site review process, the complaining person shall be offered to have the matter reviewed by the Corporate Grievance Committee. If the Corporate Grievance Committee review is requested by the complaining person, follow the steps indicated immediately below.

E. **Corporate Grievance Committee Functions and Membership.**

1. **Function.** The primary function of the Corporate Grievance Committee is to respond to BH patient-related Grievances. It may also make process improvement recommendations to the appropriate Division President. Reports on issues, complaints and actions taken to address them are forwarded to the Chief Operating Officer on at least an annual basis. This procedure governs the intake, investigation, resolution and response to patient complaints or grievances, as approved and delegated by the Board of Directors. Service



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Excellence is responsible for the management and review of the process. The Board of Directors is updated annually on the trends related to complaints and grievances.

2. **Membership**. The Corporate Grievance Committee is a system level function with broad representation. It includes a Division President, the System Chief Medical Officer, System Chief Nurse Executive, Compliance Officer, System Vice President of Performance Excellence, Deputy General Counsel, Chief Quality and Safety Officer, and System Director for Performance Excellence. The Division President is appointed by the Chief Operating Officer for a period of two years. Other resources may be accessed as needed. The Committee will be chaired by the System Vice President of Performance Excellence.
3. **Meetings**. The Corporate Grievance Committee meets as necessary to review pending Grievances and to coordinate Grievance activities or functions.
4. **Corporate Grievance Committee Review**. If the complaining person requests review of the Grievance by the Corporate Grievance Committee, the patient Grievance and any proposed resolutions are to be submitted to the Corporate Grievance Committee and the Division President. If the Division President resolves the matter before the Corporate Grievance Committee reviews, this information is forwarded to the Corporate Grievance Committee and no meeting shall be required and the Grievance shall be considered resolved.
5. **Grievance Committee Information**. If the Grievance was not resolved under Section V.D.2, the Service Excellence representative forwards the following information to the Corporate Grievance Committee:
 - a. Notes from investigations and review and medical record
 - b. Response to the issue, complaint or problem
 - c. Any supporting documentation supplied by the complaining person.
6. **Corporate Grievance Committee Review**. In reviewing the matter, the Corporate Grievance Committee may call upon resources it deems necessary and may request to meet with a facility representative and/or the complaining person. The complaining person may request to present his/her case to the Committee. The assistant to the System Vice President of Performance Excellence advises appropriate departments of the pending Grievance and meeting.
7. **Grievance Resolution**. The Corporate Grievance Committee shall propose a resolution of the matter along with a summary of its reasoning that will be forwarded to the Division President. The Division President shall review the proposed resolution and advise the Corporate Grievance Committee of his/her acceptance or disagreement with the resolution.
 - a. If there is agreement without modification, the Division President takes action to implement the resolution and the Corporate Grievance Committee provides the complaining person with information as identified in Section V.E.7.
 - b. If the Division President agrees with the proposed resolution with modification, he/she communicates the proposed modification to the Corporate Grievance



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Committee. If there is concurrence with the modification, the Division President takes action to implement the resolution as modified and the Corporate Grievance Committee provides the complaining person with information as identified in Section V. E.7.

- c. If a proposed resolution is not concurred with under V.E.7.a or V.E.7.b, the matter is referred to the System Chief Operating Officer for final resolution. The Division President takes action to implement the final resolution, and the Corporate Grievance Committee provides the complaining person with the information as identified in Section IV.E.9.
8. **Grievance Resolution Notification.** The Corporate Grievance Committee advises the Service Excellence representative and the complaining person of the resolution within ten (10) days of the decision.
9. **Grievance Summary.** Grievance responses to complaining persons contain a summary of the following information:
- a. Steps taken to investigate the matter;
 - b. Review of information at the Corporate Grievance Committee;
 - c. Date the Grievance appellate review was completed;
 - d. Decision regarding the Grievance appeal; and
 - e. The name of the appropriate facility contact person.
- F. **Reimbursement.** If reimbursement to a patient is being considered, the following process is followed:
1. The Division President/designee and/or the unit/department supervisor, upon completion of investigation, forward their recommendations to the Service Excellence representative on whether to reimburse the patient.
 2. The Service Excellence Department initiates and completes the reimbursement process based on the resolution decided upon subject to the conditions below.
 3. Lost patient property:
 - a. The unit/department supervisor obtains an estimate on the lost item(s) and documents this in the online PEF system.
 - b. The Service Excellence representative obtains approval from the Division President and follows-up with the complaining person for closure.
 - c. The Service Excellence representative contacts Legal for proper handling of reimbursement payment under claims and insurance policies.
 4. Waivers or reductions in patient bills:
 - a. Waivers and reductions in patient bills are not routinely approved as they may present a regulatory compliance issue.
 - b. Any questions concerning waivers or reductions in bills or financial courtesy extended to a patient are referred to the Patient Accounting Department.
 - c. Bill corrections are submitted to the appropriate patient accounting personnel.
 - d. The recommendation for a bill waiver, reduction, or courtesy must be reviewed with the site Controller and the Division President. Legal Affairs and/or Risk



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Management are consulted as appropriate and a determination is jointly made whether a waiver/reduction is acceptable based on the investigation.

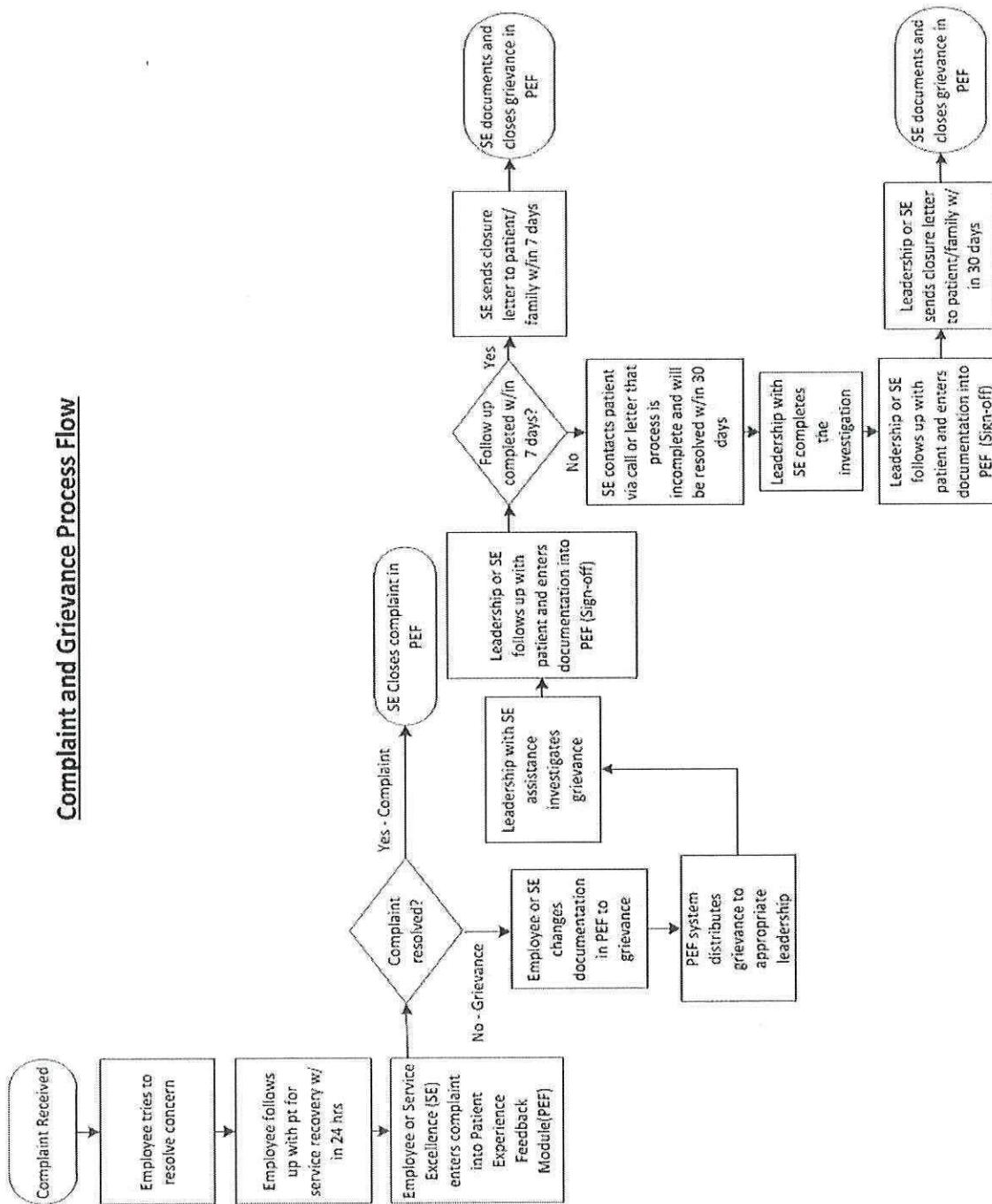
- e. The unit/department supervisor, on receiving approval for reimbursement, notifies the patient that the Service Excellence representative will make necessary arrangements.

VI. REFERENCES (if applicable): N/A

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ADDENDUM I
HOME HEALTH SERVICES

Procedures:

- A. **Processing the Complaint or Grievance** – Home Health Services aligns with the policy of Beaumont Health to ensure individuals have the right to voice complaints and grievances and to recommend changes in policy concerning their care or concerning the facility as a whole.
1. Receipt of Complaints and Grievances:
 - a. Anyone can receive a complaint. Complaints should be referred to the appropriate person (Director, Manager, Supervisor, Service Excellence Coordinator).
 - b. The complaint will be entered into the Patient Experience Feedback (PEF) for follow-up and resolution.
 - c. Complaints that are received while the employees/field staff are in the home are routinely resolved to the complainant's satisfaction during the visit (clinical, service, delivery).
 - d. If the responsible employee is unable to resolve the complaint during the visit or the complainant is not satisfied with the employee's proposed or actual resolution, the complainant shall be encouraged to voice his/her complaint to the responsible employee's director/manager/supervisor.
 - e. If the director/manager/supervisor is unable to reach a satisfactory resolution the complainant can voice his/her complaint to Home Health Service Excellence: Beaumont Home Health at 248.743.9015 and/or Oakwood Home Health at 800.757.7711 or as indicated in the patient's admission packet.
 - f. The complainant may at any time present his/her complaint to the Michigan Department of Community Health's hot line at 1.800.882.6006. The hours are Monday – Friday 8:00am – 5:00pm, and on weekends an answering machine will record the call. Unresolved complaints related to safety and quality may also be made as follows: Call the Joint Commission at 1.800.994.6610 or on line www.jointcommission.org, or call KEPRO – Beneficiary and Family Care Center- Quality Improvement Organization at 1.855.408.8557 or on line at www.kepro.qio.com.
 - g. It is the policy of Beaumont Health not to discriminate on the basis of disability. It is against the law for Beaumont Health to retaliate against anyone who files a grievance or cooperates in the investigation. Any person who believes he/she has been discriminated against on the basis of disability may file a grievance.
 - h. The complainant may at any time proceed directly to a higher level of the grievance process (described above) without fear of reprisal or discrimination.
 - i. The complainant may, at any time during the process, withdraw the complaint/grievance.
- B. **Responsibilities**

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1. Service Excellence will act as an avenue of second recourse for complainants who are not satisfied with the handling or outcome of their grievance.
2. Service Excellence is the administrator of the Home Health Services Patient Experience Feedback (PEF) and will assist the Home Services Departments with using the system.
3. Service Excellence will analyze the data for trends and make recommendations to leadership to prevent similar complaints.
4. Departments are encouraged to review the analysis of data for purposes of process improvement
5. **NOTE: After business hours and on weekends, the designated Manager is available to address complaints.**

C. Acknowledgement of Grievance

1. When a grievance is entered in the Patient Experience Feedback (PEF) system it will be sent (email) to the following applicable individuals: Vice President of HHS, Department Director, Manager, Supervisor.
2. The responsible individual(s) will investigate, follow-up and complete the written response/resolution letter if indicated.
3. Service Excellence will act as the complainant's Home Health Services contact for interim information and status updates.
4. Service Excellence will receive information from the department involved as to how the grievance was resolved.
5. Service Excellence will facilitate closure of the grievance in the Patient Experience Feedback (PEF).
6. Service Excellence will notify the applicable department when a complainant states he/she intends to register a complaint with the Office of Inspector General (OIG), the State of Michigan, Department of Community Health, Joint Commission, Community Health Accreditation Partner (CHAP) or other regulatory agencies.
7. Service Excellence will notify applicable department(s) that may include Vice President of Beaumont Home Health Services, Divisional Directors, Medical Administration, Legal Affairs and Compliance.

D. Response Time Guidelines to Grievances

1. The time frame for responding to a "grievance" is specific to the guidelines and/or regulations for each department at Home Health Services (HHS).
2. It is the intent of HHS to respond promptly to all grievances through phone call communication to the complainant, to obtain information pertinent to the investigation of the complainant. The HHS preferred time frame for responding by telephone to a complainant regarding a grievance, is within five (5) calendar days of receiving a complaint. The HHS preferred time frame for providing resolution and closure to the complainant regarding a grievance, (as applicable per each department) is within ten (10) calendar days.

E. Written Notice

1. Final resolution of a "grievance" (as applicable per each department) may require written notification to the beneficiary of the results of the investigation. The Code of Federal Regulations specify the department (as applicable per each department) provide written

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notification to the beneficiary of the results of the investigation and include in the resolution: The name of the department's contact person, notice of outcome/decision/results regarding the investigation, steps taken on behalf of the complainant to review the grievance, date the grievance was completed/closed.



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ADDENDUM II
BEAUMONT MEDICAL GROUP

Procedures:

A. **Processing.** General instructions for handling complaints received are provided below.

1. **Receipt of In-Person or Verbal Complaints.**

- a. Anyone can receive a complaint. Complaints should be referred to the appropriate person (Practice Manager or Practice Administrator).
- b. A private location is secured whenever discussing the complaint with the complaining person.
- c. Complaining persons are to receive a copy of the Beaumont Health (BH) pamphlet explaining how a complaint may be filed.
- d. Any staff present that receives a verbal complaint from a complainant shall attempt immediate complaint resolution.
- e. If the complaint is more involved than the staff is capable of remedying at the present time, then the staff present shall inform the complainant that the complaint will become a grievance and will be investigated by the appropriate manager or administrator.
- f. The Practice Manager or Practice Administrator will enter the complaint into RL Solutions.
- g. If the complaint is related to an ambulatory physician, the issue may be forwarded to the Medical Officer as necessary.
- h. The responsible management person (Practice Manager or Practice Administrator) will routinely acknowledge complaints within two (2) business days if they did not receive the complaint directly from the patient or family member.
- i. If the matter involves a significant regulatory issue or quality issue, it will be “tasked” in RL for the Director of Quality and Safety/designee.

2. **Receipt of Grievance (Written or Unresolved Complaint).**

- a. The Practice Manager that receives a grievance shall enter it into RL Solutions. The Practice Manager will follow up and begin investigation into the grievance.
- b. The Practice Manager will contact the complaining person to clarify the issue, and confirm receipt of the grievance. The complaining person will be verbally advised of the grievance process for responding to grievances. If the grievance is related to an ambulatory physician, the issue may be forwarded to the Medical Officer as necessary.
- c. The Service Excellence representative/designee will routinely follow up with the complaining person within seven (7) business days of the initial contact to share a summary of the results of the investigation and the action plan.
- d. If the matter involves a significant regulatory issue or quality issue, it will be “tasked” in RL for the Director of Quality and Safety/designee.

3. **Reimbursement.** If reimbursement to a patient is being considered, the following process should be followed:

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- a. The Practice Manager will forward their recommendation on whether to reimburse the patient to the Practice Administrator.
 - b. If patient property is lost, the Practice Manager completes documentation in RL Feedback. Practice Management shall be contacted for proper handling of reimbursement payment under claims and insurance policies.
 - c. The recommendation for a bill waiver or reduction must be reviewed by the Practice Administrator.
 - d. The Practice Manager, upon receiving approval for reimbursement, will notify Accounting to make the necessary adjustments.
 - e. **Important Note:** Waivers or reductions in the patient's bills should not be routinely approved, as they may present a regulatory compliance issue. Persons with any concerns regarding a waiver, reductions in bills or courtesy extended to a patient shall contact the Practice Administrator. A bill correction is not a waiver or reduction in a patient bill, and is not subject to this limitation.
4. **Referral to the Corporate Grievance Process.**
- a. If the grievance has not been resolved at the grievance level, the complaining person is advised of the right to file a formal grievance, as provided in the Beaumont Health Complaint and Grievance Policy.



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ADDENDUM III
REHABILITATION AND SKILLED NURSING CENTER

PROCEDURE:

- A. Any resident, the guardian of a resident, a member of the resident family, his/her designated representative, employee, or interested party, may file a formal complaint including but not limited to:
 - 1. the care and services a resident is or is not receiving.
 - 2. any violation of the resident's rights including resident abuse, neglect, and/or misappropriation of resident property in the facility.
 - 3. any condition, event or procedure in the facility.
 - 4. any believed violation of the Public Health Code, rules promulgated under the Code, or federal Medicaid and/or Medicare certification regulations applying to a skilled nursing center.
 - 5. dangerous, potentially harmful behavior of other residents.
- B. A Manager/Complaint Officer is available on each shift to receive and respond to complaints and conduct complaint investigations. The name, title, location, and telephone number of the individual responsible for receiving complaints and conducting complaint investigations is posted and accessible to residents, employees, and visitors.
- C. Each resident and/or resident representative receives a Complaint Form and the information on the Complaint Program upon admission or upon request. Complaints made to the facility may be oral or in writing. The facility will assist in transcribing oral complaints to writing. The Complaint Form should be submitted to the Manager/ Complaint Officer or any available manager.
- D. The facility will initiate an investigation within the receipt of a complaint and respond within 7 days.
- E. A written response will be delivered to the complainant following the investigation (as soon as possible or within 30 days). The Complainant is required to sign the response, indicating if the complaint was resolved satisfactorily or if further action is required. The signed response must be returned to the facility.
- F. If the complainant is not satisfied with the resolution, an appeal may be filed with the Administrator.
- G. The Complainant may file a complaint with the Michigan Department of Licensing and Regulatory Affairs (LARA). Written or oral complaints should be directed to:

Michigan Department of Licensing and Regulatory Affairs Bureau of Health Care Services - Health Facility Complaints
 PO Box 30664
 Lansing, MI 48909
 800.882.6006
- H. All complaints are filed and kept for three years and are available to the Michigan Department of LARA by request.

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