

**Incident Report Form**  
**\*\*\* CONFIDENTIAL \*\*\***

**Incident Report Number:** 44H1-007  
**Log As:** Refer to Other Agency

**Printed:** 08/10/2016  
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**Date Reported:** 11/13/2009  
**Date Submitted:** 06/22/2011

**Date of Incident:** 11/01/2009  
**Time of Incident:** :

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**FACILITY INFORMATION**

**Facility:** Four Women (44H1)  
150 Emory Street Ground Floor  
Attleboro, 02703

**ID:** 44H1  
**Type:** Clinic Form  
**Facility Reported:** No

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**INCIDENT INFORMATION**

**Incident/Allegation Type(s):** Physical Environment

**Type of Harm(s):** Unknown

**Incident/Allegation Type(s) (after DPH review):** Physical Environment

**Type of Harm(s) (after DPH review):** Unknown

**SRE Category(s):** Non-SRE  
**SRE Category(s) (after DPH review):** \*Non-SRE

**Body Part Affected(s):**

**Patient's Activity:**

**Location:**

**Equipment in Use:**

**Safety Precaution(s):**

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**INCIDENT NARRATIVE**

Consumer E-mail It was reported that the clinic from 1/1/09 to 11/7/09 is illegally disposing of fetal body parts awaiting to LJ to consult with Environmental Health. Municipal Health Department Report forwarded. It indicated that the Complainant wants to bring in evidence of fetal remains that were improperly disposed of in dumpster. Belives other offices also dumping Met with Complainant informed Complainant that facility is system regulated. 12/212 Community Sanitation conducted a site visit of the clinic on 11/4 The clinic had multiple defecencies in its medical and biological waste management. The waste storage area lacked proper signage, and appropriate security. Medical waste keeping log and policies were not maintained. The written contingency plan for spills and accidents was not maintained. The clinic was required to complete corrective actions. These include evaluating and redesigning all policies related to the handling of infectious waste, reconfiguring the storage area for medical waste, the clinic must repair the storage area ventilation system,

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**CORRECTIVE MEASURES**

**Internal Investigation?:**

**Internal Investigation Narrative:**

**Corrective Measures Narrative:**

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**FOLLOWUP INFORMATION**

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**NOTIFICATIONS**

Family: No

Police:

Physician: No

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Individual in Charge at Facility: Title: Directly Involved?:

REPORTER INFORMATION

Reporter: Title: Unknown/Other

PATIENT INFORMATION

First Name      Last Name      Age      Gender      Admission Date      Ambulatory Status      ADL Status      Cognitive Level      Developmentally Disabled

PATIENT ADDRESS

First Name      Last Name      Address 1      Address 2      City      State      Zip Code

Physician Name (if notified):

ACCUSED INFORMATION

First Name      Last Name      Gender      Title      Hire Date

WITNESS INFORMATION

First Name      Last Name      Title      Directly Involved

END OF REPORT