Incident Report Form

*** CONFIDENTIAL ***

Incident Report Number:	44H1-003	**Printed:**	08/10/2016
Log As:	Off-Site Investigation	**Page**	1 of 3
Date Reported:	04/11/2007	**Date of Incident:**	02/22/2005
Date Submitted:	06/22/2011	**Time of Incident:**	12:00

FACILITY INFORMATION

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

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

INCIDENT INFORMATION

Incident/Allegation Type(s): Nursing Services
Incident/Allegation Type(s) (after DPH review): Nursing Services

Type of Harm(s): Unknown
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):

INCIDENT NARRATIVE

COMPLAINANT LETTER The Complainant reported that the Facility utilized an individual as a certified nurse annesthetist who did not have a nursing license nor has any medical malpractice insurance. The Complainant is basing the allegation based on a name that appears on an MDPH/DHCQ SOD from 2005. Administrator of the Facility contacted by SB Administrator reports Facility utilizes licensed certified nurse annesthetists and submitted copies of credentials, insurance and appropriate relivent policies to DHCQ. There is a misspelling of the name of the certified nurse annesthetist on the 2005 SOD that the Complainant makes reference to. His credentials were included in the information submitted by the the Facility. 4/20 packet to SB for off site letter OFF SITE SD

CORRECTIVE MEASURES

Internal Investigation?:

Internal Investigation Narrative:

Corrective Measures Narrative:

FOLLOWUP INFORMATION

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