

#177



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C73  
Tallahassee, Florida 32399-3275

RECEIVED  
CONSUMER SERVICES UNIT  
2008 JAN 17 AM 11:26

**I. OFFICE INFORMATION**

Name of office: South Florida Center for Cosmetic Surgery  
 Street Address: 915 Middle River Dr #213 Fort Lauderdale, FL 33304  
 City: Fort Lauderdale Zip Code: 33304 County: Fort Lauderdale  
 Telephone: ME # 92477 / OSK # 491  
 Name of Physician or Licensee Reporting: Rudolph Viana, MD  
 License Number & office registration number, if applicable: ME # 92477 / OSK # 491  
 Patient's address for Physician or Licensee Reporting: \_\_\_\_\_

**II. PATIENT INFORMATION**

Age: 41 Gender: M  Medicaid  Medicare  
 Date of Office Visit: 01.03.08  
 Purpose of Office Visit: Follow up / postoperative  
 ICD-9 Code for description of incident: 86.22  
 Level of Surgery (I) or (II): Level III

Other: N/A see op log

**III. INCIDENT INFORMATION**

Incident Date and Time: 010308  
 Location of incident:  Operating Rm  Recovery Rm  Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
 (use additional sheets as necessary for complete response)

40-year-old patient underwent an uneventful  
contour breast lift, and  
under  
on 12.20.2007. Pt developed  
swelling / discomfort postoperatively 2 weeks post  
operatively. Pt was evaluated in office and was  
then sent for 23 hour observation at Florida Medical  
Center for  
for 4 days and was discharged to home in stable  
condition on 01.07.2008.

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-86.9)	Accident, event, circumstance, or specific agent that caused the injury or illness (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
---	---	---

C) List any equipment used if directly involved in the incident  
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred: <u>Florida Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site <input type="checkbox"/> Wrong surgical procedure performed <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure -- If 2 resulted in -- <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include toe friction scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	---

E) List all persons, including license numbers if known, locating information, and the capacity in which they were directly involved with this incident.

Andriani Marie M.D. #92477 Surgeon

F) List witnesses, including license numbers if known, and locating information if not listed above.

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analyze (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Post-operative cellulitis slip midline lift/contour fused lift + nav lift

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

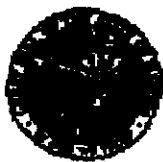
patient received antibiotic therapy, was treated and now recovered. Patient has signed on close contact with surgeon and facility.

V. [Signature] ME 92477  
 SIGNATURE OF PHYSICIAN LICENSEE SUBMITTING REPORT LICENSE NUMBER  
01-15-2008  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

1/18/08

40

#178



STATE OF FLORIDA  
Jeff Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

RECEIVED  
CONSUMER SERVICES UNIT  
08 FEB -4 PM 1:22

I. OFFICE INFORMATION

South Florida Vascular Associates

MARGATE 33063 Broward

William Julien

2825 N. State Rd 7 Suite 300

954-975-6161

ME 59991/OSR 511

Physician's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

01-18-08 Gender: [Redacted] Medical: [Redacted]

Patient Identification Number

Date of Office Visit

Diagnosis

Purpose of Office Visit

ICD-9 Code for description of incident  
Level 2 LOCAL ANESTHESIA  
Level of Surgery (0) or (1)

III. INCIDENT INFORMATION

01-18-08 1035

Incident Date and Time

Location of Incident

Operating Rm

Recovery Rm

Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Pt. was scheduled for a simple [redacted] in the office with local anesthesia which usually takes 3-4 minutes duration. Upon removal of the catheter, Pt. [redacted] head and saw the catheter as it was being [redacted] of. Pt. suddenly reports that [redacted] was feeling [redacted] to verbal and deep painful stimuli. Vital signs [redacted] were normal. Sp. O2 sat within normal range 99-100%. Normal saline IV started on [redacted] @ RVO rate. After observing Pt. for 20-30 min. Condition remains unchanged from responsive verbally but had mod. ability to head and turning head to answer questions.

EMERGENCY ER Physician Dr. J. Wallace and Pt. Neurologist Dr. Subramaniam were notified of Pt. condition. Report given to ER. Pt. transported to EMERGENCY ER for observation. Neurological workup was done to include Ct. Scan, MRI of the brain, EEG. Pt. was about to receive TPA treatment Pt. suddenly began to move and wanted to go home. [redacted] was discharged home the next day in normal condition. (See Dr. Julien's dictation as well as hospital note will follow.)

**B) ICD-9-CM Codes**

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 86-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-899.9)
--	--	--

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred <u>Northwest Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** If it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	---

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

WILLIAM M. JULIEN MD ME 59991  
CHARLINE BERRONET RN 1366692  
KAREN, CARR, RN 2597332

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

IRIS ALVARADO  
Kristie Latesky

**IV. ANALYSIS AND CORRECTIVE ACTION**

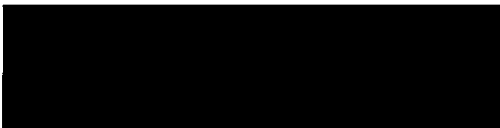
**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

PE has a [redacted] to any medical procedure of seeing body fluids or blood. [redacted] nephrologist says the dialysis center has to cover [redacted] face for the 3 hrs of dialysis so [redacted] would see [redacted] blood.

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

We will avoid performing any procedures on this patient. However, if we have to we will cover [redacted] face so [redacted] cannot see any IV tubing, catheters, blood, etc.

Willie [redacted] ME 59991  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
1-31-01 274  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



# FAX COVER SHEET

TO [REDACTED]

COMPANY AHCA

FAX NUMBER 18504880796

FROM Debra Conn

DATE 2008-01-22 22:47:41 GMT

RE Office Surgery Adverse Incident



## COVER MESSAGE

Hi [REDACTED],

I am filing this adverse incident report for J. David Holcomb, M.D. though it is questionable as if it requires filing. The patient was brought into the OR and sedated for surgery. After the injection of local anesthesia [REDACTED] heart rate elevated and was not responding well to medication. The case was cancelled and the patient was transferred to Sarasota Memorial Hospital.

Dr. Holcomb has followed with the cardiologist and it was noted that the patient had a TSH of 0 (no history of thyroid disease and this is not a standard pre-op test). [REDACTED] has remained hemodynamically stable and is now being treated for [REDACTED] thyroid condition.

Surgery will be re-scheduled for 3 months after [REDACTED] has cardiology clearance.

Please call if you have any questions.

Debbi

RECEIVED  
CONSUMER SERVICES UNIT  
2008 JAN 23 AM 7:32



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bldg C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Holcomb Facial Plastic Surgery  
Name of office

Sarasota 34237 Sarasota  
City Zip Code County

S. David Holcomb, MD  
Name of Physician or Licensee Reporting

1 S. School Ave, Ste 800  
Street Address

(941) 365-8679  
Telephone

ME80017, 370  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

Age 1/21/08 Gender [Redacted] Medical Insurance [Redacted]  
Date of Office Visit 1/21/08  
Purpose of Office Visit Elective Facial Surgery  
ICD-9 Code for description of Incident non-fatal tachyarrhythmia  
Level of Surgery (I) or (II) (I)

III. INCIDENT INFORMATION

1/21/08 ~ 10:45 AM  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)  
Hemodynamically stable non [Redacted]  
[Redacted] (50 cc 0.5% lidocaine / 0.25% marumine / 11200,000 qpi).  
Heart rate decreased to 110 after Breivibloc 10 mg q 3-5 min x 3 doses and Vempanil 2.5mg q 3 min x 2 doses. No incisions were made. IV sedation was discontinued. Patient was transported via EMS to Sarasota Memorial Hospital for further evaluation. Patient awake, alert and verbal upon transfer.

**B) ICD-9-CM Codes**

<i>preparation for level II office surgery</i>	<i>Unknown</i>	<i>NA</i>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)	Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

*NA*

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer - e.g., death, brain damage, observation only <i>observation and treatment</i> Name of facility to which patient was transferred: <i>Sarasota Memorial Hospital</i>	<input checked="" type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** If it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	--

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

<i>Jay Horowitz, CRNA</i>	<i>ARNP 2699782</i>	<i>Anesthesia</i>
<i>Michelle Shields, RN</i>	<i>RN 921774</i>	<i>Circulation</i>
<i>Teri Jarvis, LPN</i>	<i>PN 909121</i>	<i>Surgical Scrub</i>

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

*NA*

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

*Unknown versus sympathetic effect.*

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

*See narrative on page 1.*

**V.**

<i>[Signature]</i>	<i>ME80017</i>
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
<i>1/21/08</i>	<i>4pm</i>
DATE REPORT COMPLETED	TIME REPORT COMPLETED



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

7 ✓

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

CAG Laboratories, LLC  
Name of office  
Gainesville 32605 Alachua  
City Zip Code County  
Burton Silverstein, MD  
Name of Physician or Licensee Reporting

4645 NW 8th Ave  
Street Address  
(352) 375-1212  
Telephone  
ME0033054 / 431  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]  
Diagnosis

[Redacted]  
Age 1-23-08 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_  
Date of Office Visit \_\_\_\_\_  
Purpose of Office Visit \_\_\_\_\_  
ICD-9 Code for description of incident 427.31  
Level of Surgery (II) or (III) II

III. INCIDENT INFORMATION

1-23-08 0934  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other Cath Lab Rm 6

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See attached documentation

RECEIVED  
CONSUMER SERVICES UNIT  
SUPERVISOR  
FEB 10 7 38 AM '08  
DH-MQA1030-12/06  
Page 1 of 2



B) ICD-9-CM Codes

427.31/CPT=92960

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

427.5  
879.9

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

427.31

Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident

(Use additional sheets as necessary for complete response)

Biphasic defibrillator, Oxygen, Patient Monitoring (BP, SpO2, Heart monitor)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer – e.g., death, brain damage, observation only <u>Permanent Pacemaker</u> Name of facility to which patient was transferred: <u>Shands AGH</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	---

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

See attached documentation

F) List witnesses, including license numbers if licensed, and locating information if not listed above

See Attached Documentation

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

See Attached Documentation

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

See Attached Documentation

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME0033054

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

**CONFIDENTIAL**  
FDOH January 2008 report  
Physician Office Adverse Incident Report  
Addendum to Report from Cardiology Associates of Gainesville Laboratories

**Section III – Incident Information**

**A) Describe circumstances of the incident:**

- Patient was here for an elective synchronized cardioversion. The indication for procedure was “Recurrent atrial fibrillation/flutter with controlled ventricular response; previous cardioversion June 13, 2007.”
- Informed consent was obtained and patient was prepared for procedure in the usual manor. In the room at the time were Dr. Burton Silverstein, Miranda Jensen, RN, and Carla Owns, CMA.
- The patient’s vital signs, blood pressure, heart rate and rhythm, respirations, and oxygen saturations were being monitored.
- Patient was placed on oxygen at 2L via nasal canula.
- Patient was sedated as per physician order, using Versed 3 mg IV and Fentanyl 75 mcg IV.
- At this time 200-watt seconds of biphasic synchronous energy was applied with resultant asystole. The patient was asked to cough with no significant response.
- Doctor Silverstein and Miranda immediately started CPR and initiated ACLS protocols. An overhead page noting the cardiac arrest was called per policy and EMS was called by telephone.
- Additional staff (see list) arrived to support the team present with the life saving procedures.
- After 9 minutes of resuscitation efforts, an EKG was obtained showing an underlying left bundle branch block; it appeared that atrial fibrillation/flutter persisted.
- At that time EMS arrived, and the patient’s O2 saturation was > 90%. [REDACTED] was awake, alert, and moving all four extremities.
- The patient was then transported via EMS to Shands AGH

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

1. Burton Silverstein, MD; *ME 0033054* – First MD responder
2. Miranda Jensen, RN; *RN9183748* – first RN responder
3. Carla Owens; *CMA NCMA 579249*- first CMA responder
4. Amy Jones, RN; *RN 3213382*-code team responder
5. Marianne Thompson; *RCIS 13818* - code team responder
6. Nancy Davis, ARNP; *RN 1769372*- ARNP responder
7. Kim Giberti, RN; *RN 275059* - code team responder
8. Bernard Gros, MD; *ME 0073065* - second MD responder
9. Ryan Guskiewicz, CVT – code team responder
10. Kathy Crofts; *CNMT 017037, NCT 80182, RT(N)39657* - code team responder
11. Shannon Williams, CNA; *CNA# 1292589364637* - CNA responder with EKG
12. Lynne Mercadante; *RN 0980452* -crowd control/family support
13. Isabella Dario; *CMA 42154, CCT 34200* - code team responder

**CONFIDENTIAL**  
**EDOH January 2008 report**  
**Physician Office Adverse Incident Report**  
**Addendum to Report from Cardiology Associates of Gainesville Laboratories**

**F) List witnesses, including license numbers if licensed, and locating information if not listed above.**

1. Burton Silverstein, MD
2. Miranda Jensen, RN
3. Carla Owens, CMA

**Section IV - ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent causes) of this incident:**

The cause of this event is unknown, however, asystole is a known risk of synchronized cardioversion. The patient had undergone the same procedure 7 months prior without incidence.

**B) Describe corrective or proactive action(s) taken:**

- The day of the incident, all involved participated in a "post code" conference, at which time it was noted that all involved responded in accordance with the policy, and that our policy is consistent with the standards set by the State. Possible enhancements to policy were identified, and a timeline was created for implementation of these changes.
- The patient's records from the office were sent with the patient to Shands AGH. There, cardiologist Michael Dillon, M. D., (the admitting physician) reviewed the records and found that the care the patient received was within the standard of care.

**Section V**

\_\_\_\_\_  
Signature of Physician/Licensee Submitting Report

ME 0033054  
\_\_\_\_\_  
License Number

02/05/08  
\_\_\_\_\_  
Date Report Completed

1700  
\_\_\_\_\_  
Time Report Completed



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit:  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office: Space Coast Cancer Center  
City: Titusville FL Zip Code: 32796 County: Brevard  
Physician: Dr. Richard Levine

Street Address: 850 Century Medical Drive  
Telephone: 321-268-4240  
40927  
(License Number & office registration number, if applicable)

Physician's address (if different from office reporting)

II. PATIENT INFORMATION

[Redacted Patient Information]

Age: [Redacted] Gender: [Redacted] Medicaid/Medicare: [Redacted]  
Date of Office Visit: 1/31/08  
Purpose of Office Visit: 780.09  
ICD-9 Code for description of incident: N/A  
Level of Surgery (II) or (III): N/A

III. INCIDENT INFORMATION

Incident Date and Time: 1/31/08 12:00

Location of Incident:  
 Operating Room  Recovery Room  
 Other: office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No N/A  
Was an autopsy performed?  Yes  No N/A

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

[Redacted Narrative]

RECEIVED  
CONSUMER SERVICES UNIT  
000 MAR 19 AM 9:26

**B) ICD-9-CM Codes**

N/A  
 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)      Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)      Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
 (Use additional sheets as necessary for complete response)

AED, Ambu Bag, O2

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital. Outcome of transfer – e.g., death, brain damage, observation only Name of facility to which patient was transferred: <u>Farrish Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure. ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
---	--

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

Dr. Richard Levine 40927 Edwan Hill RN  
Melissa Alexander RN 9215092  
Elizabeth Rivera  
Shelly Copeland RN 9225330

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

Terry Holmes - Lab Tech

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

O2 placed, legs elevated, AED placed, ambulance called, after pt lost consciousness

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

O2 placed on patient, AED placed, ambulance called, possible pharyngeal hypotensive due to blood

**V.**  
[Signature]      40927  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER  
3-11-08      12:00  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

HEMATOLOGY ONCOLOGY CONSULTANTS  
Name of office  
TAMPA City 33606 Zip Code HILLSBOROUGH County

2111 SWANN AVE #102 Street Address  
(813) 254-7227 Telephone

HAFEEZ T. CHATOOR MD  
Name of Physician or Licensee Reporting

ME 00160783  
License Number & office registration number, if applicable

[Redacted]  
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]  
Patient's Name  
Patient's Date of Birth  
Patient's Insurance Number  
Diagnosis LYMPHOMA CHEST PAIN

[Redacted]  
Age 1-30-08 Gender Male Medicaid Medicare  
Date of Office Visit  
Purpose of Office Visit  
ICD-9 Code for description of incident N/A  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1-30-08 1415  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other PHYSICIAN'S OFFICE

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No N/A

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

PATIENT ARRIVED TO OFFICE FOR SCHEDULED PORT FLUSH. [Redacted]  
PRESENTED PALE AND DISTRESSED. PATIENT STATED [Redacted] HAD CHEST PAIN  
NOW AND HAS HAD CHEST PAIN FOR 2 WEEKS ON AND OFF. [Redacted] THOUGHT  
IT WAS [Redacted] PACEMAKER WHICH WAS RULED OUT PRIOR TO [Redacted] COMING  
HERE. V.S. TAKEN: PULSE RANGED 134-145 BPM BP 159/94  
O2 ALPHANOC APPLIED. DR CHATOOR ASSESSED PT. NITROGLYCERIN 1/150gr  
ADMINISTERED SL. EMS CALLED. UPON ARRIVAL PT ASSESSED  
BY EMS. PT TAKEN TO TAMPA GENERAL HOSPITAL VIA AMBULANCE.

**B) ICD-9-CM Codes**

Surgical, diagnostic, or treatment procedure being performed at time of incident  
(ICD-9 Codes 01-89.9)

Accident, event, circumstances, or specific agent that caused the injury or event.  
(ICD-9 E-Codes)

Resulting injury  
(ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

OXYGEN UNIT

**D) Outcome of Incident (Please check):**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only <u>OBSERVATION</u> Name of facility to which patient was transferred <u>TAMPA GENERAL HOSPITAL</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input checked="" type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	---

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

ELLEN SMILEY RN 2822572 RN INITIALLY ASSESSING PATIENT  
HAFEEZ CHATTOO MD 0060783 MD

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

PAULA MESICK RN  
PAMELA JAMES RN

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

PATIENT ARRIVED WITH CHEST PAIN AND SENT TO ER VIA EMS

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

N/A

**V.**

Hafeez Chattoo 0060783  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
01-30-08 1500  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Hematology & Oncology Consultant  
Name of office  
Sun City Center 33573 Hillsborough  
City Zip Code County  
Ruth Wheeler, RN  
Name of Physician or Licensee Reporting

4051 Upper Creek Drive, Suite 104  
Street Address  
813/633-3955  
Telephone  
RN  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted patient information]

Age 1-17-06 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_  
Date of Office Visit \_\_\_\_\_

Diagnosis \_\_\_\_\_

Purpose of Office Visit 4019  
ICD-9 Code for description of Incident N/A  
Level of Surgery (II) or (III) \_\_\_\_\_

III. INCIDENT INFORMATION

11/12/05 @ 9:30  
Date and Time

Location of Incident  
 Operating Room  Recovery Room  
 Other OFFICE

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No N/A

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

PATIENT presented to office for routine visit - presented at Ambulatory w/o complaints - B/P taken and was 200/100. Rechecked @ 2:35/100 with HR 103 - patient complained of being diaphoretic and dizzy - Dr Robbins notified - B/P rechecked @ 10:30 and B/P was 233/112 HR 107 - Dr Robbins notified - Nitro paste 1" applied to (R) chest wall as ordered and paramedics called for transport to ER for evaluation



**B) ICD-9-CM Codes**

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
---	---	---

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred <u>SOUTH BAY HOSPITAL</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	---

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

RUTHingles RN 2745892

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

UNKNOWN cause of Hypertension - patient on BP meds and reported [redacted] took them this am as ordered

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

WATER PASTE 1" APPLIED

V. Dorelingles RN 2745892  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
11/17/03 4:00 P.M.  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

X

SUBMIT FORM TO:  
Agency for Health Care Administration,  
Consumer Services Unit, Post Office Box 14000,  
Tallahassee, Florida 32317-4000

I. OFFICE INFORMATION

Southeastern Urological Center  
Name of office

2000 Centre Pointe Blvd  
Street Address

Tallahassee 32308 Leon  
City Zip Code County

850-309-0400  
Telephone

Byron Blasko ARNP  
Name of Physician or Licensee Reporting

1554842  
License Number & office registration number, if applicable

Same as above  
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

Patient Identification Number  
Retention  
Diagnosis

Date of Office Visit: 1-10-08  
Gender: NA  
Medicaid: NA  
Medicare: NA  
Purpose of Office Visit: NA  
ICD-9 Code for description of incident: NA  
Level of Surgery (II) or (III): NA

III. INCIDENT INFORMATION

1-10-08 @ 3:00 pm  
Incident Date and Time

Location of Incident:  
 Operating Rm  
 Recovery Rm  
 Other physician's office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Patient presented for catheter removal and upon checking vital signs [redacted] ARNP called to room and patient is becoming less and less responsive. EMS called for emergency transport to TMH. Noted patient had taken nitroglycerine the night before for chest pain and had taken [redacted] blood pressure med this morning. Assessed and treated at TMH for about 10 hours and released.

**B) ICD-9-CM Codes**

<u>NA</u>	<u>NA</u>	<u>NA</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

NA

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only <u>observation &amp; treatment</u> Name of facility to which patient was transferred <u>IMH</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Doris Blasko RN 155 4842 treating practitioner  
Patricia Kelly MA Check in staff  
Shelley Keenan RN RD 273706 charge nurse assisting with transfer

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

Patient presented for cath removal but had an unrelated non-urologic

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

Transfer appropriate and necessary for non-urologic condition

V. [Signature] RI 915912  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
1-14-08 1200  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor



**PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT**

**SUBMIT FORM TO:**  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

**I. OFFICE INFORMATION**

Name of office: Hematology/Oncology Consultants  
City: Swan City Center 33573 Zip Code: Hillsborough  
Name of Physician or Licensee Reporting: Ruth S. Hughes RN

Street Address: 4051 Upper Creek Dr., Suite 104  
Telephone: 913/633-3955  
License Number & office registration number, if applicable: RN 2745892

Patient's address for Physician or Licensee Reporting

**II. PATIENT INFORMATION**

Patient's Address: [Redacted]  
Patient Identification Number: 204.10  
Diagnosis: [Redacted]

Age: 1/9/08 Gender: [Redacted] Medicaid/Medicare: [Redacted]  
Date of Office Visit: [Redacted]  
Purpose of Office Visit: [Redacted]  
ICD-9 Code for description of Incident: [Redacted]  
Level of Surgery (II) or (III): [Redacted]

**III. INCIDENT INFORMATION**

Incident Date and Time: 1/9/2008 @ 1050

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other: OFFICE

Note: If the incident involved a death, was the medical examiner notified?  Yes  No N/A  
Was an autopsy performed?  Yes  No

**A) Describe circumstances of the incident (narrative)**  
(use additional sheets as necessary for complete response)

PATIENT WAS pre-medicated with Tylenol 650mg PO, Sedmedrol 4mg IV/PO and Benadryl 25mg IV/PO - [Redacted] was initiated @ 50cc/hr - After 30 minutes when I went to get B/P, pt complained of not feeling well - [Redacted] was [Redacted] and faint - Dr Robbins was notified and in attendance - pt's feet were elevated, infusion had been stopped and bolus of NS was initiated - Pulse OX was 98% - patient was transported to same ER for evaluation - discharged with treatment administered @ HOSPITAL

**B) ICD-9-CM Codes**

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	<u>RITUXAN INFUSION</u> Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
---	--	---

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response) N/A

**D) Outcome of incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred <u>SOUTH BAY HOSPITAL</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

DR MARK ROBBINS, MD - 53990 - ATTENDING  
Angella Brown - RN - 2953642

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

BONNY KAER - RN 2667562  
214 Aberdeen PONDLE, Apollo BEACH, CA 33572 813/758-2734

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

PATIENT HAD REACTION TO INFUSION OF RITUXAN OR VAPORACAL  
Epinephrine

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

PATIENT WAS PRE-MEDICATED PER PROTOCOL AND STILL HAD  
REACTION - WILL NOT RECEIVE ANY MORE OF THIS DRUG

**V.** [Signature] RN RN 2745892  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
11/16/08 0920  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



B) ICD-9-CM Codes

74130 / 789.01  
 Surgical, diagnostic, or treatment  
 procedure being performed at time of  
 incident  
 (ICD-9 Codes 81-99.9)

308.00  
 Accidental, event, circumstances, or  
 specific agent that caused the injury  
 or event.  
 (ICD-9 E-Code)

Cold a Shivering  
 Resulting injury  
 (ICD-9 Codes 800-899.9)

C) List any equipment used if directly involved in the incident  
 (Use additional sheets as necessary for complete response)

D) Outcome of incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only. Name of facility to which patient was transferred: <u>Monter Memorial</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** If it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function <input type="checkbox"/> Any condition that required the transfer outcome of the patient
--	--

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Michelle Gonzalez Lo H 216377  
Dr. Weinberg  
Wally

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

taken by EMS to Monter Hospital

B) Describe corrective or prescriptive action(s) taken (Use additional sheets as necessary for complete response)

V. Abundance Hernandez ME 41255  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
1/3/02 2/02  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

2/4/08 #11

#179



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

RECEIVED  
CONSUMER SERVICES UNIT  
2008 FEB 14 PM 2:51

I. OFFICE INFORMATION

Orlando Aesthetic Institute  
Name of office  
Orlando 32804 Seminole  
City Zip Code County  
D. Scott Rotatori, MD  
Name of Physician or Licensee Reporting

120 E. Par Street, Suite 1000  
Street Address  
(407) 770-2002  
Telephone  
OSR 570  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]  
Age 2-4-08 Gender Medical Medicare  
Date of Office Visit  
Purpose of Office Visit  
ICD-9 Code for description of incident  
Level of Surgery (II) or (III)

Patient Identification Number

Diagnosis

III. INCIDENT INFORMATION

2-4-08 at 10:58 AM  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No NA  
Was an autopsy performed?  Yes  No NA

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

10:58 Patient was received in the post anesthesia care unit post abdominoplasty. Anesthesia (Dr. Deborah Caroli) and Dr. Scott Rotatori in attendance. Lung sounds positive for crackles/rales bilateral lung respirations unlabored with O2 4L/nasal canula. Head of bed elevated. 1125 - medications given (Lasix 10mg) Dr. Rotatori + Dr Caroli consulted and decided to transfer patient to Florida Hospital South. Family informed of situation. Patient remained in post anesthesia care unit, monitored until transfer by ambulance company to Florida Hospital at 12:55.

RECEIVED  
CONSUMER SERVICES UNIT  
2008 FEB 14



**B) ICD-9-CM Codes**

15831 / 272.8      507.0 vs. 518.4      NA  
 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)      Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)      Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
 (Use additional sheets as necessary for complete response)

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer, e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: <u>Florida Hospital South</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** If it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	---

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

Donald Scott Rotatori, MD ME51444 (Surgeon) Krystina Rodio (Assistant)  
Deborah Caroli, MD ME72917 (Anesthesia) Etta Rich, ARNP (Director)  
Jennifer Smith, RN (PACU) RN9225173 ARNP 1680032  
Donna Boden, LPN (PACU) PN900951

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

Per our policies + procedure it was necessary to transfer the patient to the hospital for further work up.

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

Followed protocol.

v. Heather C. Gledarov, MHA, LHM      5503735  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER  
2.12.08      3:36pm  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED

2/6/08 #12

#36



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4062 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3276

**I. OFFICE INFORMATION**  
CONTINUUM CARE MDPC, LLC - WESTCHESTEL  
Name of office  
MIAMI 33155 DADGE  
City Zip Code County  
KASHEM SULTAN, MD  
Name of Physician or Licensed Provider

8608 BIRD ROAD  
Street Address  
305-551-3200  
Telephone  
HCC 15482  
License Number & office registration number, if applicable

**II. PATIENT INFORMATION**  
[Redacted]  
Patient Identification Number [Redacted]  
Diagnosis 2nd to  
DEGENERATIVE JOINT  
DISEASE L3-L4-L5  
LUMBAR RADICULOPATHY

[Redacted]  
2/6/08  
Date of Office Visit  
Purpose of Office Visit [Redacted]  
ICD-9 Code for description of incident  
N/A  
Level of Surgery (X) or (Y)

**III. INCIDENT INFORMATION**  
2/6/2008 @ 12:30pm  
Incident Date and Time

Location of Incident  
 Operating Room  Recovery Room  
 Other WAITING AREA

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

**A) Describe circumstances of the incident (narrative)**  
(Use additional sheets as necessary for complete responses)  
A [Redacted] YO [Redacted] with PMH significant for HTN, CAD, DM,  
Episodes of syncope of unknown cause, one 2/6/08 at 12:30 pm  
the patient was found [Redacted]  
[Redacted] in area while waiting discharge and transportation.  
When first seen by me, pt was unresponsive, pupils fixed  
and dilated, dusky colour, not breathing, with questionable  
faint carotid pulse.  
patient was laid on the floor and CPR with standard treatment  
is immediately started and 911 was called, premed team arrived

(see reverse page)

Sultan  
2.21.08

Continue:

arrived at around 12:45 pm where other measures were taken including intubation and Delib for obvious A-Fib. Pt was then transferred to Baptist Hospital HD stable with strong palpable peripheral pulse but no change in neurological status.

Prior to the incident the patient had a regular follow up for pain management for lumbar spondylitis and radiculopathy. The patient had an ~~anesthesia chart~~ and was placed for postop. observation at 11:30 am. Pt was able to ambulate without any motor weakness. Pt however complained of one episode of vomiting which was improved completely by Zofran. Pt was then transferred to the waiting area where the incident happened half an hour later.

Sulta 2.21.08

B) ICD-9-CM Codes  
 lumbar epidural block  
 one hour prior to the incident  
 Surgical, diagnostic, or treatment  
 procedure being performed at time of  
 incident (ICD-9 Codes 01-89.9)

cardiac event  
 Accident, event, circumstances, or  
 specific agent that caused the injury  
 or event. (ICD-9 E-Code)

Hypoxic brain damage  
 Resulting injury  
 (ICD-9 Codes 800-899.9)

C) List any equipment used if directly involved in the incident  
 (Use additional sheets as necessary for complete response)

N/A

D) Outcome of incident (Please check):

<input type="checkbox"/> Death	<input checked="" type="checkbox"/> Surgical procedure performed on the wrong site **
<input checked="" type="checkbox"/> Brain Damage	<input checked="" type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input checked="" type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.
<input type="checkbox"/> Surgical procedure performed on the wrong patient.	
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure.	** If it resulted in:
<input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.	<input type="checkbox"/> Death
Outcome of transfer -- e.g. <u>death</u> , brain damage, observation only <u>Death 2/18/08</u>	<input type="checkbox"/> Brain Damage
Name of facility to which patient was transferred: <u>Baptist Hospital Miami</u>	<input type="checkbox"/> Spinal Damage
	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function.
	<input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

HASHM SULTAN, MD ME 0075271 - PAIN SPECIALIST  
JOSE A. GONZALEZ - ANESTHESIOLOGIST MD ME 006707 - WESTCHESTER PHYSICIAN  
DEBORAH MECK, RN RN 1896952 - DIRECTOR OF CLINICAL COMPLIANCE  
TERESA DE ALENAS ADMINISTRATOR WESTCHESTER

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

the incident seems to be an obvious coincident to the pain treatment. cardiac event like A-Fib, SSS, Asystole, V-Fib is most likely cause.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

To be determined by the administration. PRESENTLY ALL SUCH PROCEDURES ARE DISCONTINUED IN HOSPITAL CARE OFFICES. N/A

V.

Hashm Sultan ME 0075237  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
2-21-08 2:35 pm  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

2/7/08

#43

#180



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

RECEIVED  
CONSUMER SERVICES UNIT  
2008 FEB -7 9:29 AM

I. OFFICE INFORMATION

Name of office: Jeffrey Epstein, MD, PA  
City: Miami Zip Code: 33143 County: Dade

Street Address: 6280 Sunset Dr, Suite 504  
Telephone: 305-666-1779  
License Number & office registration number, if applicable: ME0059544

Name of Physician or Licensee Reporting: Jeffrey Epstein  
Patient's address for Physician or Licensee Reporting: 6280 Sunset Dr. Suite 504, Miami, FL 33143

II. PATIENT INFORMATION

[Redacted patient information]

Age: [Redacted] Gender: [Redacted] Medicaid/Medicare: [Redacted]  
Date of Office Visit: [Redacted]  
Purpose of Visit: [Redacted]  
ICD-9 Code for description of incident: [Redacted]  
Level of Surgery (II) or (III): [Redacted]

III. INCIDENT INFORMATION

Incident Date and Time: \_\_\_\_\_

Location of Incident:  
 Operating Room  Recovery Room  Other \_\_\_\_\_

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)  
Pt had [redacted] under MAC.  
Total procedure time - 5 1/2 hours.  
At time of discharge, pt had received no IV sedation.  
For 3 1/2 hours prior, and [redacted] reported that 30 minutes  
earlier [redacted] had the sensation of needing to void very soon  
after voiding. At that time [redacted] was discharged. [redacted]  
reported that [redacted] had voided again and was feeling  
fine. Pt given Rx app for the next day and the  
Surgeon's office phone number. That evening, spouse with patient's  
[redacted] who informed me pt had [redacted]  
Since that time, patient has [redacted]  
for at least 3 days. Total IV fluids - 750cc over 5 hours.

**B) ICD-9-CM Codes:**

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
---	---

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

*patient is a regular user of oxycontin for a chronic back pain condition. This combined with 8 hours in the recovery room, led likely to a [redacted]*

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

*1) Review photo and 93 hrs*

V. *[Signature]* ME 0059544  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
10/4/07 \_\_\_\_\_  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

2/19/08

#44

#181



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

Name of office Cardiology Consultants, PA  
City Pensacola Zip Code 32501 County Escambia  
Name of Physician or Licensee Reporting Nancy A. Riddlebover, RN Clinical Director  
Patient's address for Physician or Licensee Reporting See Below

Street Address 1717 North "E" Street Suite 331  
Telephone 850-444-1717  
License Number & office registration number, if applicable N/A

II. PATIENT INFORMATION

Patient Name [Redacted]  
Patient Age [Redacted]  
Patient Gender [Redacted]  
Patient Identification Number [Redacted]  
Diagnosis CAD & Myocardial Infarction  
Left Ventricular Dysfunction EF 34%  
Angina & Positive Nuclear Stress Test  
Ischemic Cardiomyopathy

Age 02-19-08 Gender [Redacted] Medicaid  Medicare   
Date of Office Visit [Redacted]  
Purpose of Office Visit 518.4 Acute  
ICD-9 Code for description of incident NA  
Level of Surgery (II) or (III) [Redacted]

III. INCIDENT INFORMATION

Incident Date and Time 02-19-2008

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Outpatient Cardiac Cath Lab.

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  NA  
Was an autopsy performed?  Yes  No  NA

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See Attached.





DOB: [REDACTED]

Incident Date: 02-19-2008

Page 1 of 1

**Description of circumstances of the incident:**

Patient scheduled for [REDACTED] Heart Catheterization [REDACTED] Coronary Artery Grafts. Hx. of CAD with four vessel CABG in 2004, recent Angina with Positive Nuclear Stress Test and EF 34%. Pre-Cath: End diastolic pressure 38 mm/Hg., Lasix 40mg IV given. Bilateral edema 1 + lower extremities. BUN 41, Creatinine 2.1. Sodium BiCarb drip IV started. BP elevated 215/112. Nitroglycerin 1 inch topically applied and Vasotec 1.25 mg IVP administered. Pulse 64 bpm Sinus Bradycardia. Oxygen Sat. 96%. During Procedure [REDACTED] oxygen increased to 4 L NC. Post Cath [REDACTED] with patient complaining of severe SOB. Sinus Tachycardia, pulse rate 114 bpm. [REDACTED] Physician assessed patient and orders received for treatment and transfer to hospital for admission for [REDACTED] implantation.

**Analysis and Corrective Action:**

A. Analysis (apparent cause) of this incident:

Left Ventricular dysfunction with ejection fraction of 34% and past history of Beta Blocker intolerance due to bradycardia.

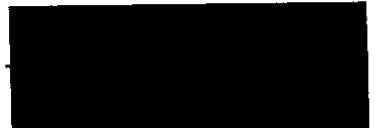
B. Describe corrective or proactive action(s) taken:

Patient was treated with Oxygen at 100% per Re-Breather Mask, Albuterol Nebulizer, Vasotec 1.25 mg IV, Nitroglycerin 0.4 mg Sub-Lingual. During the procedure the Left Ventriculogram was deferred to conserve contrast due to elevated LVEDP of 38 mmHg. Cath findings: Three Vessel CAD, patent sequential SVG to OM1, OM2, PLB, PDA, Patent LIMA to LAD. Recommendation: Medical Treatment, Echo to fully evaluate LV function, Pacemaker or ICD possibly, to allow for Beta blocker treatment. On 2-20-08 ICD was implanted.

2/23/08

#45

#182



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4082 Bald Cypress Way, Bldg C76  
Tallahassee, Florida 32309-3276



I. OFFICE INFORMATION

South Florida Center for Cosmetic Surgery  
Name of office 915 Middle River Dr #213 Fort Lauderdale, FL 33304  
City Fort Lauderdale Zip Code 33304 County Broward  
Name of Physician or Licensee Reporting Jon Haxcell, DO Telephone 954-565-7515 License Number & office registration number, if applicable OS #441

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 5.8 Gender Male Medicaid  Medicare   
Date of Office Visit [Redacted]  
Purpose of Office Visit [Redacted]  
ICD-9 Code for description of incident [Redacted]  
Level of Surgery (I) or (II) [Redacted]

III. INCIDENT INFORMATION

7-21-08 6:00 P.M.  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other (Name of Hospital)

Note: If the incident involved a death, was the medical examiner notified?  Yes  No N/A  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

PT. UNDERWENT SURGERY OF TORSO JULY 3, 2008. [Redacted] HAD AN UNEXPECTED SURGERY AND HAD NO ANESTHETIC PROBLEMS. OVERALL THE PT. WAS RECOVERING WELL FROM THE PROCEANAS AND HAD RETURNED TO WORK. ON JULY 27, 2008, [Redacted] 19TH POST-OPERATIVE DAY [Redacted] HAD AN EPISODE OF LIGHT HEADINESS, SHORTNESS OF BREATH. [Redacted] PRESENTED TO THE HOSPITAL AND WAS DIAGNOSED AS HAVING A [Redacted]. [Redacted] WAS PLACED ON ANTICOAGULANT THERAPY. DISCHARGED ON JULY 28, 2008 IN GOOD CONDITION OPERATING DR. IN CONTACT WITH PT. AND HOSP. DR. DURING COURSE OF TREATMENT [Redacted] AFTER RECALL OF ADMISSION.

2/25/08

#46

#183



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bfn C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office: Cardiology Consultants, PA  
City: PENSACOLA Zip Code: 32501 County: Escambia  
Name of Physician or Licensee Reporting: NANCY A. Riddlehouse, RN, Clinical Director  
Patient's address for Physician or Licensee Reporting: Listed Below

Street Address: 1717 North "E" Street  
Telephone: 850-444-1717  
License Number & office registration number, if applicable: NA

II. PATIENT INFORMATION



Age: 02-25-08 Gender: \_\_\_\_\_ Medicaid/Medicare: \_\_\_\_\_

Diagnosis: acute Systolic Heart Failure  
Severe Aortic Stenosis  
Severe Valvular Cardiomyopathy  
Severe Aortic

Date of Office Visit: \_\_\_\_\_  
Purpose of Office Visit: 428.D  
ICD-9 Code for description of incident: \_\_\_\_\_  
Level of Surgery (I) or (II): \_\_\_\_\_

III. INCIDENT INFORMATION

Incident Date and Time: 02-25-2008 @ 9:46 AM

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other: Outpatient Cardiac Catheterization Lab

Note: If the incident involved a death, was the medical examiner notified?  Yes  No NA ✓  
Was an autopsy performed?  Yes  No NA ✓

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See Attached

**B) ICD-9-CM Codes**

935216 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)  
428.0 Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)  
NONE Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
 (Use additional sheets as necessary for complete response)

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only <u>Aortic Valve Replacement</u> Name of facility to which patient was transferred <u>Baptist Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Safwan Jaalouk, MD FACP, FACC, FSCAI, ME 11797, Cardiology Physician - 1717 N. E Street, Pensacola  
Patty Lynch - Rad. Tech - CRT # 33488 - Radiology Tech - Scrub - 1717 N. E Street, Pensacola  
Linda Kuhnell, RN - License # 9176749 - Recording Nurse - 1717 N. E Street, Pensacola  
Tracy Bokath, RN - License # 92163229 - Circulating Nurse - 1717 N. E Street, Pensacola

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

Sylvia Matthews, RN - License # 1210952 - 1717 N. E Street, Pensacola  
Jennifer Mathews, RN - License # 31511692 - 1717 N. E Street, Pensacola

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

Increasing Stenosis of Aortic Valve causing increase in Systolic dysfunction and associated symptoms of heart failure.

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

Admitted to Hospital for diagnosis and Replacement of Aortic Valve.

V. (Vander A. Riddle) RN 737742  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
7-3-08 1:40 PM  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

DOB: [REDACTED]

Incident Date: 02/25/2008

Page 1 of 1

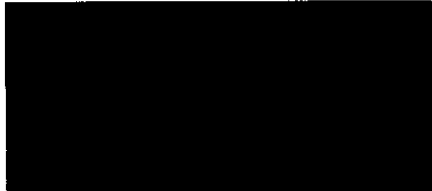
Description of circumstances of the incident:

Patient arrived to outpatient cath lab for a Right and Left Heart Catheterization for Severe Aortic Stenosis. During the procedure patient became short of breath. Lasix 40 mg. IVP given with oxygen applied at 2 Liters/minute by Nasal Cannula. Repeat Lasix 40 mg. IVP administered within six minutes. Oxygen Saturation 91%. When cath procedure completed patient became severely short of breath. BP 129/86, Pulse 117 bpm., Respiration 24/min. Lasix 40 mg. IVP repeated, Nitroglycerin Paste 1 inch applied to chest wall. Oxygen increased to 4 Liters/min. per NC. Albuterol Treatment given. Oxygen saturation 98%. Physician ordered patient transferred to Hospital Emergency Department to be [REDACTED] for diuresis and surgical [REDACTED] for Aortic Valve [REDACTED] placement.

2/2/08

#188  
#47

#184



STATE OF FLORIDA  
Charlie Crist, Governor



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

Duplicate? ✓

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

**I. OFFICE INFORMATION**

TALLAHASSEE PLASTIC SURGERY CLINIC  
Name of office

Tallahassee, FL 32308 Leon  
City Zip Code County

H. Louis Hill, Jr., M.D.  
Name of Physician or Licensee Reporting

\_\_\_\_\_  
Patient's address for Physician or Licensee Reporting

Old address: 1704 Riggins Road

New address: 2452 Mahan Drive Suite 101  
Street Address

850-877-2126  
Telephone

ME 26697  
License Number & office registration number, if applicable

**II. PATIENT INFORMATION**

\_\_\_\_\_  
Patient Identification Number

\_\_\_\_\_  
Diagnosis

Age 02/27/08 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_

\_\_\_\_\_  
Purpose of Office Visit

99.4  
ICD-9 Code for description of incident

III  
Level of Surgery (II) or (III)

**III. INCIDENT INFORMATION**

02/27/08 Approx. 1:45pm  
Incident Date and Time

Location of Incident:  
 Operating Room     Recovery Room  
 Other \_\_\_\_\_

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
 Was an autopsy performed?  Yes  No

**A) Describe circumstances of the incident (narrative)**  
 (use additional sheets as necessary for complete response)

On 2/27/07 Dr. Louis Hill performed breast augmentation surgery on \_\_\_\_\_ that did not resolve in the appropriate amount of time post operatively. She was subsequently scheduled for revision of her right breast on 1/29/08. The second procedure was performed at the new location of 2452 Mahan Drive Suite 102. Findings at the time of the second procedure included \_\_\_\_\_ The sponge was removed, the implant was replaced, and the patient was notified of the event.

Dr. Hill has already refunded \_\_\_\_\_ payment for the January 29, 2008 surgery, and has agreed to refund all monies the patient expended for the February 27, 2007 surgery, together with reimbursement for lost wages she incurred as a result of the second surgery. Further, should the patient develop a capsular contracture or infection as a result of the retained sponge, Dr. Hill has agreed to treat these conditions free of charge.

Root cause analysis of the event indicates that the OR Policy requiring two correct counts at the end of every procedure was not followed. No counts were noted on the OR record. Steps have been taken to rectify this situation to prevent recurrence.

RECEIVED  
CONSUMER SERVICES  
2008 FEB 25 AM 7:4

**B) ICD-9-CM Codes**

CPT: 19325

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

E 871.0

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

998.4

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

Raytec sponge

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input checked="" type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  <b>** if it resulted in:</b> <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	--

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

L. Wainwright, R.N.—Circulating Nurse RN3047832

M. Tyson, C-ST - Scrub tech. 102704

M. Frankland, M.D.—anesthesiologist ME 82396

H. Louis Hill, Jr., M.D.—surgeon ME24697

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

Root cause analysis indicates that the OR policy of having two correct counts at the end of every case was not followed.

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

The OR staff and surgeon involed have met to discuss the situation and have agreed that this lapse in policy is not acceptable. ALL OR cases are to have documented two correct counts, or X-Ray evidence that a foreign body has not been left in the patient. V. Raytec gauze is no longer used in any breast cases.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME24697  
LICENSE NUMBER

2/18/08  
DATE REPORT COMPLETED

1:00 pm  
TIME REPORT COMPLETED



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C79  
Tallahassee, Florida 32399-3276



I. OFFICE INFORMATION  
Name of Office: Space Coast Cancer Center  
City: Titusville Zip Code: 32796 County: Brevard  
Name of Physician or Licensee Reporting: Dr. Juan Castro  
Address of Physician or Licensee Reporting: [Redacted]

Street Address: 850 Century Medical Drive  
Telephone: 321-268-4200  
License Number & office registration number, if applicable: 73059

II. PATIENT INFORMATION

[Redacted Patient Information]

Age: 2/12/68 Gender: \_\_\_\_\_ Medicaid/Medicare: \_\_\_\_\_  
Date of Office Visit: Follow-up  
Purpose of Office Visit: Med. M  
ICD-9 Code for description of Incident: 786.05  
Level of Surgery (I) or (II): Nil

III. INCIDENT INFORMATION

Incident Date and Time: 2/12/08

Location of Incident:  
 Operating Room  Recovery Room  
 Other: Med's office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Patient came in to the office on oxygen. [Redacted] was complaining of shortness of breath. Vital signs HR 102, BP 10/70 were taken temperature was 103.7 Sats 77%. [Redacted] was scheduled for an office visit with Dr. Castro. M.D. did see [Redacted] was sent to ER via ambulance.

RECEIVED  
CONSULTER SERVICES UNIT  
2008 MAR 26 AM 9:58







STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

X

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Space Coast Cancer Center  
Name of office

Merritt Island 32952 Brevard  
City Zip Code County

Michelle Pillow RN  
Name of Physician or Licensee Reporting

225 Cone Rd, MI Florida  
Patient's address for Physician or Licensee Reporting

225 Cone Rd.  
Street Address

321-453-1361  
Telephone

License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

Diagnosis

[Redacted Patient Information]

Age Gender Medicaid Medicare

2-6-08  
Date of Office Visit

[Redacted]  
Purpose of Office Visit

ICD-9 Code for description of incident

n/a  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2-6-08  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No NA  
Was an autopsy performed?  Yes  No N/A

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Pt came into the office today, crying. No ↑ pain around [redacted] Infusaport. Pt describes pain as severe stabbing pain at [redacted] port site. The port is located on the ⊕ chest wall. Katie Wilkerson, ARNP saw the pt. The IFF was flushed & see heparin (500u) It flushed well, good blood return noted. No swelling or redness around site. Katie, ARNP ordered 911 to be called. Pt transported to CAPE Canaveral Hospital via Ambulance Lto R/O cardiac involvement.

RECEIVED  
CONSUMER SERVICES UNIT  
2008 MAR 17 AM 9:43

**B) ICD-9-CM Codes**

Surgical, diagnostic, or treatment procedures being performed at time of incident  
(ICD-9 Codes 01-89.9)

Accident, event, circumstances, or specific agent that caused the injury or event.  
(ICD-9 E-Codes)

Resulting injury  
(ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only ( <u>Observation only</u> ) Name of facility to which patient was transferred <u>Cape Commercial Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Michelle Pillow, RN - flushed infusion port in the room - RN 9187143  
Katie Wilkeson, RNLP - IV pt, assessed pt - RNLP 3073572

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

AS ABOVE

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

Pt went to ER → had a CT chest.  
no evidence for pulmonary embolism or clot.  
Pt's lung cancer has progressed - new tumors noted @ Lung

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

N/A      Obstruction noted  
② upper lobe bronchus

**V.**      Michelle Pillow RN      RN 9187143  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER  
2/7/08      10:30 AM  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Agency for Health Care Administration,  
Consumer Services Unit, Post Office Box 14000  
Tallahassee, Florida 32317-4000

I. OFFICE INFORMATION

Southeastern Urological Center  
Name of office

2000 Centre Pointe Blvd  
Street Address

Tallahassee 32308 Leon  
City Zip Code County

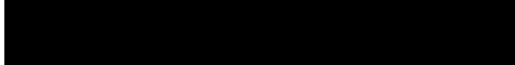
850-309-0400  
Telephone

Gregory Lemerenda PA  
Name of Physician or Licensee Reporting

PA9101919  
License Number & office registration number, if applicable

Same as above  
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 2-21-08 Gender \_\_\_\_\_ Medicaid/Medicare \_\_\_\_\_

\_\_\_\_\_  
Patient Identification Number

\_\_\_\_\_  
Date of Office Visit

\_\_\_\_\_  
Diagnosis

NA  
Purpose of Office Visit

NA  
ICD-9 Code for description of incident

NA  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2-21-08 @ 2:45 pm  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Physician's office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Patient presented for evaluation of testicular pain. During evaluation it is noticed that the patient is [redacted], [redacted], [redacted]. Dr. Camps views patient and orders transport for evaluation of symptoms. ER physician notified and report given. UA taken with elevated Blood pressure, tachycardia and pulse oximetry at 95%. IV started, Oxygen started and patient started feeling better. EMS to transport to TMH

B) ICD-9-CM Codes

<u>NA</u>	<u>NA</u>	<u>NA</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident

(Use additional sheets as necessary for complete response)

NA

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital <hr/> Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred: <u>TMH</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Joseph L Camps MD - ME 0057214 - physician of record - ordered transfer  
Gregory Lamendola PA - PA 9101919 - PA seeing patient scheduled  
Patricia Kelly MA - assisting PA with patient visits  
Patricia Lebrun Johnson RN - RN 519082 - Charge Nurse assisting with transfer  
Terry J Spear RN - RN 915912 - caring for patient till transfer

F) List witnesses, including license numbers if licensed, and locating information if not listed above

as above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response).

patient had non-urologic condition causing symptoms - [redacted] was status post op for colon resection.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Appropriate transfer for non-urological symptoms

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED



RECEIVED  
SERVICES  
10 AM 7:51

STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Agency for Health Care Administration,  
Consumer Services Unit, Post Office Box 14000,  
Tallahassee, Florida 32317-4000

I. OFFICE INFORMATION

Watson Clinic, LLP  
Name of office  
Lakeland FL 33805 Polk  
City Zip Code County  
Neddie M. Howell RN  
Name of Physician or Licensee Reporting  
Nurse Run Clinic, LLC  
Locating Information for Physician or Licensee Reporting

1100 Lakeland Hills Blvd  
Street Address  
(863) 680-7000  
Telephone  
RN 1467312  
License Number

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]  
Age 2-7-08 Gender Nulliparous Medicaid Medicare  
Date of Office Visit  
Purpose of Office Visit  
414.00  
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

2-7-08  
Incident Date and Time

Location of Inc  
 Operating Room  Recovery Room  
 Other Injection room

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

For myomax stress test. IV started + myomax dose given in Nuc Med Dept.  
Pt felt lightheaded, became [Redacted]  
[Redacted] Reagined consciousness, warmth + color. IV Normal  
Saline infused 500cc. After 150ccs pt sat up + then got  
into chair. BP + Pulse ↓. Assisted to stretcher + taken to  
urgent care per telephone order of PCP Dr. Jalkabickz. Pt. had  
existing heart disease with history of chest pain.  
In urgent care, experienced some chest pain. No hives,  
edema, urticaria. To Hospital (LHMC) for observation



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

**I. OFFICE INFORMATION**  
Cardiology Consultants, PA  
Name of office  
Pensacola 32501 Escambia  
City Zip Code County  
NANCY A. Riddlehomer, R.N., BSN.  
Name of Physician or Licensee Reporting  
N/A  
Patient's address for Physician or Licensee Reporting

5151 N. 9th Ave Suite 200  
Street Address  
850-857-1700  
Telephone  
N/A  
License Number & office registration number, if applicable

**II. PATIENT INFORMATION**  
[Redacted]  
Patient Identification Number  
Diagnosis [Redacted]

[Redacted]  
Age 2-7-2008 Gender [Redacted] Medicaid Medicare  
D [Redacted]  
Purpose of Office Visit 519 call and 786.09  
ICD-9 Code for description of incident N/A  
Level of Surgery (II) or (III)

**III. INCIDENT INFORMATION**  
2-7-2008 11<sup>34</sup> AM  
Incident Date and Time

Location of Incident  
 Operating Rm  Recovery Rm  
 Other Office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See Attached

RECEIVED  
CONSUMER SERVICES UNIT  
2008 MAR 14 AM 7:38

B) ICD-9-CM Codes

J0152 : 93D15      J0152      NONE  
 Surgical, diagnostic or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.E)      Accident, event, circumstances or specific agent that caused the injury or event. (ICD-9 E-Codes)      Resulting injury (ICD-9 Codes 800-995.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response) N/A

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - <u>no damage, observation only</u> Name of facility to which patient was transferred: <u>Baptist Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	---

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Thax S. Ha Duong-Wagner, M.D. FACC, ME 77423, 1717 N.E Street, Pensacola, Responding MD.  
LINA CERULLO - HAMILTON, RN License # 9196234, 1717 N.E Street, Pensacola, Nurse  
Linda Kuknell - RN License # 9116749, 1717 N.E Street, Pensacola, Nurse Responding  
Regina Johnson - MA, 1717 N.E Street, Pensacola, Assisted with emergency  
Terry Barker, MA, 1717 N.E Street, Pensacola - Stress Tech.

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

See Attached

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

See Attached

V. Handa G. Reddy      737742  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER  
02-25-08      3:38 PM  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED



[REDACTED]

**Incident Date: 02/07/2008**

Page 1 of 1

III. Incident Information:

A) Description of circumstances of the incident:

The patient underwent IV infusion of 140 mcg/kg/min of adenosine over a 5 minute period. Baseline heart rate was 49 bpm. Resting blood pressure was 132/82 mmHg, and nadir blood pressure was 102/60 mmHg. Immediately in the recovery period, the patient was noted to have [REDACTED], with heart rate as low as 35 and developed significant shortness of breath. Blood pressure was 102/60 with [REDACTED]. The patient was also noted to [REDACTED].

IV. Analysis and Corrective Action:

A) Analysis (apparent cause) of this incident:

[REDACTED]

B) Description of corrective or proactive action(s) taken:

Atropine 1.0 mg intravenous was given, with improvement of heart rate up to 118 bpm and blood pressure increased to 160/100 at 9 minutes post Adenosine. Oral airway immediately inserted and patient was given oxygen per bag-mask and Emergency Team was activated. Before the paramedics arrived, [REDACTED] oxygen saturation had already improved to 98-100% and [REDACTED] cyanosis completely resolved and the patient was clinically stable. [REDACTED] was transported to the emergency room for further monitoring and evaluation. ECG with Adenosine infusion did not show any ischemic changes. The patient was discharged from the hospital the next day.

B) ICD-9-CM Codes

Left Heart Cath - 93510  
Femoral Bypass - 75630      Ischemic Extremity - 459.9      NONE  
 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)      Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)      Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident  
 (Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g. death, brain damage, observation only <u>Fem-Pop Bypass Graft</u> Name of facility to which patient was transferred <u>Baptist Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
--	--

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

William S. Pickens MD, FACC, Lic # ME 23808 - Cathing Physician - 1717 N.E. St. Suite 331, Pensacola  
Patty Lynch, RT (Lead Tech), CRT # 33488 - Scrub / Radiology Tech - 1717 N.E. St. Suite 333, Pensacola  
Linda Kuhnelt - RN - License # 9176749 - Circulating Nurse - " " " " " "  
Sylvia Matthews - RN - License # 1210952 - Recording Nurse - " " " " " "

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Tracy Bokath - RN - License # 92163229 - 1717 North E. St. Suite 331, Pensacola  
Jennifer Mathese - RN - License # 3151692 - " " " " " "

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

See Attached

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

See Attached

V.

Barbara A. Biddehoorn RN  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT  
7-16-08  
 DATE REPORT COMPLETED

737742  
 LICENSE NUMBER

5:30 PM  
 TIME REPORT COMPLETED

DOB: [REDACTED]

Incident Date: 03-04-2008

Page 1 of 1

Description of circumstances of the incident:

Patient arrived for ~~Left Heart Catheterization/Aortography/Femoral Runoff~~. Post cath, in the recovery room, patient complained of Right knee pain and right foot feeling numb. ~~Dorsalis pedis pulse to right femoral artery~~. Right posterior tibial pulse present with doppler. ~~Right dorsalis pedis pulse absent~~.

Analysis and Corrective Action

A. Analysis of this incident:

Patient with history of Peripheral Vascular Occlusive Disease with Aortobifemoral bypass in 2001. New onset of bilateral leg pain [Right greater than Left]. Ultrasound of bilateral lower extremities on 12-07-2007 found mild to moderate peripheral vascular occlusive disease involving the bilateral extremities with occluded bilateral proximal to mid superficial femoral arteries with the collaterals noted at mid distal superficial femoral arteries bilaterally. Patient also has history of CAB 2001, Renal Insufficiency, Ischemic Cardiomyopathy with ejection fraction of 15% (ICD implanted 2006), Occluded Saphenous vein graft to right coronary artery from cath in March 2007.

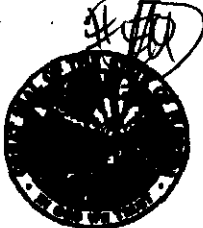
March 4, 2008 Cath Findings: Normal LVEDP, Normal Renal Arteries, Aorto-bifemoral graft, 50% Right Common Femoral Stenosis, Bilateral superficial femoral artery occlusions. Good runoff distally. Recommendations: ~~Surgical Consult~~.

B. Corrective or proactive actions taken:

Cathing Physician notified immediately. Heparin 10,000 units given IV. Surgeon notified. Heparin 5,000 units given IV. IV Heparin drip started at 1000 units /hour. Patient transferred to hospital. On 03-06-2008 patient had ~~Femoropopliteal bypass graft above the right knee~~, exploration of right femoral limb of aortobifemoral bypass graft with embolectomy of the right femoral limb of [REDACTED] aortobifemoral bypass graft, and embolectomy of profunda femoral artery. Patient tolerated procedure well.

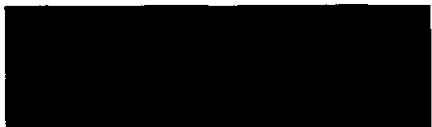
3/12/08

#49



#186

STATE OF FLORIDA  
Jeb Bush, Governor



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

2008 APR 21 PM 2:19  
SUBMIT FORM TO:

Agency for Health Care Administration,  
Consumer Services Unit, Post Office Box 14000,  
Tallahassee, Florida 32317-4000



I. OFFICE INFORMATION

COSMETIC SURGICAL GROUP

Name of office  
MIAMI, 33175 DADE

City Zip Code County  
MIAMI E. PRUSTAS

Name of Physician or Licensee Reporting  
13055 SW. 42 St.

Locating Information for Physician or Licensee Reporting

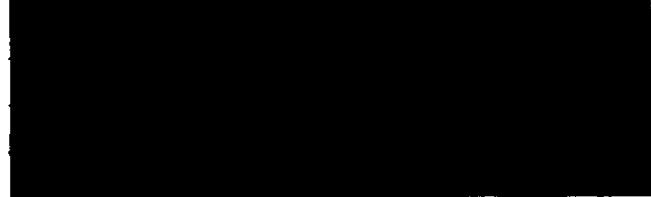
13055 SW. 42 St

Street Address  
305 - 828 8380.

Telephone  
MI 828 8380

License Number

II. PATIENT INFORMATION



Age 49 Gender Male Medicaid Medicare

Date of Office Visit DISCHARGED.

Purpose of Office Visit WK.

ICD-9 Code for Diagnosis

Diagnosis [REDACTED]

III. INCIDENT INFORMATION

3.12.08 time UNKNOWN  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other HOME

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

[REDACTED] AT MIAMI, FL.  
RETROAUGURAL [REDACTED] AT WEST PALM BEACH  
ON 3.11.08. PATIENT WAS ADMITTED ON A  
HOSPITAL ON THAT LOCATION. [REDACTED]  
DISCHARGED LATER.  
FOLLOW UP AT MIAMI, OFF. NO COMPLICATIONS

B) ICD-9-CM Codes

W/A

W/A

W/A

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response) W/A

D) Outcome of Incident (Please check) W/A

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input type="checkbox"/> Any condition that required the transfer of the patient to a licensed hospital	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure <p>** If it resulted in</p> <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer of the patient
--	--

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Personnel Present ME 67165

F) List witnesses, including license numbers if licensed, and locating information if not listed above

W/A

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Apparent cause was that narrow bed patient home was above at time of incident.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

W/A

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

3/14/08 #50

#187



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Miami Institute for Age Management  
Name of office  
Miami 33131 Miami Dade  
City Zip Code County  
Adam Rubenstein, MD  
Name of Physician or Licensee Reporting  
19495 Biscayne Blvd #200/20 Aventura FL 33180  
Patient's address for Physician or Licensee Reporting

1941 Brickell Ave  
Street Address  
305-624-4009  
Telephone  
OSR #501  
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

Age 3/14/08 Gender Medicaid Medicare  
Date  
Purpose of Office Visit  
ICD-9 Code for description of incident  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

3/14/08 17:45  
Incident Date and Time

Location of Incident:  
 Operating Room  
 Recovery Room  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

In [redacted] Patient's [redacted] abruptly [redacted]  
[redacted] Succinyl Choline and  
Morphine given and patient was re-intubated. Good breath  
sounds then heard bilaterally and positive BCO2 seen.  
Tube was secured. Rhonchi heard in both lung bases.  
Decision was made to transfer Patient to Mount  
Sinai Hospital

**B) ICD-9-CM Codes**

21.87, 86.83, 86.89

E876.9

998.9

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

NONE

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer - e.g. death, brain damage, observation on _____ Name of facility to which patient was transferred: <u>Mount Sinai Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	---

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

ME 77538 Surgeon  
OS 7770 Anesthesiologist

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

RN 9246246  
PN 1186771

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

patient's reaction to anesthesia  
\_\_\_\_\_

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

Diligent auscultation of lungs when positioning laterally.  
Use of anesthetic agents that are eliminated more rapidly (eg Sevoflurane).

**V.**

[Signature] Adam Rubinstein, MD ME 77538  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
03/28/08 09:30  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

3/19/08

#188

#51

#188



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

WALNUT CREEK MEDICAL CENTER  
Name of office

1779 N. UNIVERSITY DRIVE SUITE 10  
Street Address

LEWISBURG AVENUE 33024 BROWARD  
City Zip Code County

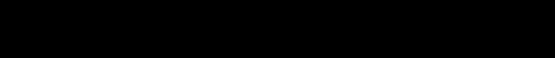
954 963-0888 / 954 964-6287  
Telephone

BRANT DOORLE, MD ME 85567  
Name of Physician or Licensee Reporting

(ME85567) 05R598 JH  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 05-19-2008 Gender Medicaid Medicare

Patient Identification Number

Date of Office Visit

Diagnosis

Purpose of Office Visit

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

3/19/2008 1130H  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other procedure room

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

SEE ATTACHED.



**B) ICD-9-CM Codes**

45380 for 789.07

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-899.9)
--	--	--

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

Colonoscope (olympus)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital. Outcome of transfer - e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure. ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	---

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

DR. RICHARD KUSHNICK (ANES), CHRIS COLIN (RN) Florida  
KRYAN (RN), Ned James (Tech), Dr. Brian Doolack (Gastroenterologist)

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

Same as above

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

[Redacted]

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

See narrative.

**V.**

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA1030-12/06

Page 2 of 2

RE: [REDACTED]  
DATE OF PROCEDURE: 03/19/2008

[REDACTED] was seen in consultation on January 30, 2008 with thirty years of chronic abdominal pain. [REDACTED] does use Librax and Nexium for [REDACTED] symptoms. [REDACTED] does have a history of diverticulosis and a hiatal hernia. [REDACTED] last colonoscopy was more than ten years ago.

After the risks, benefits, alternatives were discussed and questions answered cardiopulmonary monitoring was established with oxygen delivery. The oropharynx was topically anesthetized, bite block inserted; patient in left lateral decubitus position. MAC anesthesia (Dr. Kushnick) was introduced.

Sedation obtained; the endoscope introduced under direct visualization. The esophageal mucosa was normal with a hiatal hernia and a normal Z-line. There was gastropathy with no ulceration. Retroflexion was unremarkable. Patent pylorus with normal duodenal mucosa and green bile. Gastric biopsies were taken.

The external anal mucosa examined. Sedation was maintained. Digital examination; good tone, no masses. The colonoscope was advanced under direct visualization to the cecum identified by ileocecal valve and appendiceal orifice. The preparation was adequate. The mucosa was examined carefully with slow timed withdrawal. The mucosa was erythematous in the transverse and ascending colon. There as an area of moderate to severe diverticulosis in the left side. No large polyps were seen. Random biopsies were taken of the right colon.

During withdrawal [REDACTED] vital signs were stable, however [REDACTED] abdomen was bloated. Air was withdrawn to the best of our ability and intravenous antibiotics (intravenous Flagyl 500 mg) was given. Vital signs were stable post-procedure. The patient was explained in detail regarding need for further evaluation with an X-ray and EMS was contacted in addition to the emergency room.

The case was discussed with the emergency room physician and a colorectal surgeon who meet the patient there. The situation was again explained to the patient. Upon arrival the ER [REDACTED] vital sign were stable, X-ray without any evidence of free air and normal labs including a CBC. [REDACTED] was seen an evaluated by a colorectal surgeon. Initial impression was retained air.

A CT completed after that point showed [REDACTED] mostly extraperitoneal. No free intraperitoneal air was seen. [REDACTED] enlarged with a right hemicolectomy. [REDACTED] no perforation seen on the pathologic specimen, however right sided erosions were noted with a thin colonic wall raising the possibility of a healed chronic colitis.

[REDACTED] hospital course was uneventful with a timely appropriate discharge. [REDACTED] was seen daily and the family spoken to everyday. [REDACTED] has been seen in follow-up already doing well without any complaints, surgical complications or abdominal pain.



3/21/08

#58



#37

STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Mid-Florida Cardiology Specialists  
Name of office  
Ocoee                      34761                      Orange  
City                              Zip Code                      County  
Mouaz Tawam, M.D.  
Name of Physician or Licensee Reporting  
10,000 West Colonial Drive Suite 282  
Patient's address for Physician or Licensee Reporting  
Ocoee, Florida 34761

10,000 West Colonial Drive Suite 282  
Street Address  
407-351-5384  
Telephone  
ME 65619  
License Number & office registration number, if applicable

II. PATIENT INFORMATION



[Redacted]  
Age                      Gender                      Medicaid                      Medicare  
03/21/2008  
Date of Office Visit  
[Redacted]  
Purpose of Office Visit  
427.41 Ventricular Fibrillation fort  
ICD-9 Code for description of incident  
N/A  
Level of Surgery (I) or (II)

Coronary artery                      [Redacted]                      [Redacted]  
Diagnosis                      chest pain

III. INCIDENT INFORMATION

03/21/2008 at 14:20  
Incident Date and Time

Location of Incident:  
 Operating Room                       Recovery Room  
 Other Stress Lab

Note: If the incident involved a death, was the medical examiner notified?  Yes     No  
Was an autopsy performed?  Yes     No (Family Member's request)

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

PLEASE REFER TO SEPERATE SHEET DESCRIBING INCIDENT  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RECEIVED  
2008 MAY 16 PM 2:55

### III. INCIDENT INFORMATION

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

██████████ underwent a cardiolute spect stress test for chest discomfort, known coronary artery disease on previous cardiac catheterization.

#### CARDIOLITE SPECT STRESS TEST

**INDICATION:** Chest discomfort, known moderate coronary artery disease on previous cardiac catheterization.

**I. Exercise Stress Physiology:** Informed consent was obtained. The patient was exercised using a standard Bruce protocol for a total exercise time of 8:52 minutes. The maximum workload was 10.4 METS. The test was stopped due to fatigue and achievement of targeted heart rate.

Baseline heart rate was 104 bpm. Blood pressure was 124/88. Peak heart rate attained was 173, which is above 85% of maximum predicted for age. Maximum blood pressure was 180/120.

Baseline EKG revealed normal sinus rhythm with normal axis and interval. The patient reported 3/10 chest discomfort in early recovery. The EKG revealed 2-3 mm of ST elevation in the right precordial leads, onset at peak stress. Chest discomfort and ST elevation resolved within 2 minutes in recovery.

Later in recovery the patient developed ██████████. ██████████ was still hooked up to the stress test monitor. ACLS protocol was promptly initiated and the patient received CPR and multiple defibrillation shocks with 360 joule direct current shocks prior to the arrival of the paramedics and the cardiac arrest team. Resuscitation attempts were continued as described in the cardiac arrest code team note (Health Central Nurses Note).



### III. INCIDENT INFORMATION

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers. (Continued)

Kim Solomon-Scheduling Supervisor responded to in office code alert within 15 seconds at the stress lab, immediately called the Health Central Code Team in the Emergency Room in the first floor of the same building of our office suite.

Elizabeth Paucar Administrative Assistant responded to in office code alert and arrived within 15 seconds at the stress lab, immediately called 911 for assistance with the code. HCPS #203 was dispatched to our suite.

Mouaz Tawam, M.D. patient's physician at bedside during first ST elevation noted and assisted with code in the stress lab (ACLS/BLS). ME65619

Javier Lorenz, M.D. physician present in the office when code was called in the stress lab. He went into the stress lab to assist with the code (ACLS/BLS). ME0042458

Health Central Hospital Code Team called immediately at the Health Central Emergency Department located on the first floor to assist with the code. Code team arrived within 1-2 minutes once they where called to the stress lab and assisted with the code. Health Central Hospital Code Team is located in the same 10,000 W. Colonial Drive address as Mid-Florida Cardiology Specialists (2<sup>nd</sup> floor, Suite 282).

HCPS (Health Central Paramedic Services) #203 responded to our 911 call and assisted with the code, arrived within 2-3 minutes once they where called. The HCPS #203 is also located within the Health Central Hospital premises near the emergency room in the same building as our office is located.

All of the above Mid-Florida Cardiology Specialists personnel are located at:  
10,000 W. Colonial Drive  
Suite 282  
Ocoee, Florida 34761

Health Central Hospital Code Team and the HCPS ((Health Central Paramedic Services) personnel are located at:  
10,000 W. Colonial Drive  
Ocoee, Florida 34761  
Or near the Health Central Hospital Emergency Room.

**IV B. Describe corrective or proactive action(s) taken**

**This unfortunate event occurred due to the patient's underlying cardiac condition, and would not have been predictable or preventable based on the patient's history and presentation. The practice did perform a quality assurance review of its stress lab, and no corrective action was indicated. Mid-Florida Cardiology Specialists already requires BLS and ACLS certification for stress lab personnel, all nurses, LPN and RN, and physicians. In addition, all of the ACLS medical equipment is provided and available at each stress test lab to include defibrillator and code cart. Measures are already in place for quality control of this equipment. Supplies and equipment were ordered to restock the facility as necessary to continue to facilitate possible code responses. In summary, no corrective action was indicated by the quality assurance review, and the [REDACTED] was not caused by an injury or accident, but due to the patient's cardiac condition.**



#38

STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4062 Bald Cypress Way, Bin C76  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

STEVEN SCHUSTER, MD, PA  
Name of office  
BOCA RATON 33496 PALM BEACH  
City Zip Code County  
STEVEN SCHUSTER, MD  
Name of Physician or Licensee Reporting  
SAME AS BELOW  
Patient's address for Physician or Licensee Reporting

1905 Clint Moore Rd., #101  
Street Address  
561-912-9191  
Telephone  
ME 48641 #328  
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted Patient Information]  
Patient Identification Number  
Diagnosis

[Redacted Patient Information]  
Age 3.21.08 Gender Medical/Medicare  
Purpose of Office Visit  
Malignant Hyperthermia  
ICD-9 Code for Description of Incident  
Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

March 21, 2008 9:35  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

SEE ATTACHED SHEETS



B) ICD-9-CM Codes

VSD - Hypertonia

Platypnea Hypertensive

Death

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)

Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident

(Use additional sheets as necessary for complete response)

Anesthesia Machine, Boovie Electrocautery, Puff Monitor, AED

D) Outcome of Incident (Please check)

<input checked="" type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer - e.g., death, brain damage, observation only <u>Death</u> Name of facility to which patient was transferred: <u>Delray Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** If it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	---

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Steven Schuster MD - Plastic Surgeon ME 48641  
Dexter Warheit, MD - Anesthesiologist ME 53287  
Cheryl Ledac, RN - Circulating Nurse RN 3203932  
Donna Randolph, - Scrub Tech

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Michelle Voskovich, RN RN 1523662

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

SEE ATTACHED SHEETS

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

SEE ATTACHED SHEETS

V.

Steven Schuster MD ME 48641  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
4-2-08 10 PM  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

**III.A. Describe the circumstances of the incident (narrative)**

██████████ was an ██████ year old ██████ who was referred to me by her mother for a breast augmentation. Her history was unremarkable and her mother had no history of anesthetic problems having recently undergone general anesthesia. She was desirous of a breast augmentation to become a full C cup. She also had inverted nipples as an aside which she wanted corrected at the same time if possible.

After a consultation and examination she was deemed an appropriate candidate for a breast augmentation using saline implants. She was offered the option of surgery in the office, surgicenter or hospital and chose to have surgery in the office setting. Surgery was scheduled for the following Friday March 21, 2008 at 7:30AM

██████████ underwent pre-op education and routine blood work about a week prior to surgery, which was found to be normal. Her pre-op booklet was reviewed with her and she had ample time to ask questions of both my nurse and myself at that meeting. She said she had no further questions and was ready to proceed.

On the morning of surgery she met with Dr. Peter Warheit, her anesthesiologist for this case. History was obtained from ██████ with her mother present and no anesthetic complications were known. Father was not available and when ██████ (mother) was queried about his anesthetic history she did not know of any problems in the past with anesthesia.

After induction of anesthesia by Peter Warheit, MD the patient was prepped and draped in the usual manner. Time out was performed for a breast augmentation and possible correction of inverted nipples. Surgery proceeded uneventfully through the decision of which size implant to use by placing the patient in the semi-seated position. The patient was then placed back in the supine position. Dr. Warheit noted a change in the patient's status and after thorough evaluation felt that patient was ~~apneic~~ ~~hypotensive~~ ~~bradycardic~~ ~~hypothermic~~ would estimate this time to be about 9:35 AM.

At that time the procedure was aborted and the incisions closed with staples as expeditiously as possible. Staff was instructed to obtain as much ice as possible and call EMS to obtain emergency transport to Delray Medical Center and start mixing Dantrolene. During the time between the call to EMS and their arrival the initial 3 bottles of Dantrolene were mixed and a new IV started as patient rapidly appeared vasoconstricted. While this was occurring Dr. Warheit supported and managed the cardio respiratory system. During this time patient developed ~~an arrhythmia~~ ~~as~~ diagnosed by Dr. Warheit and the AED was placed on the patient. The patient was shocked which put her into a sinus rhythm. When patient had stopped clenching down on the LMA the tube was changed to an endotracheal tube.

The first 2 bottles of Dantrolene had already been given and the third ready to be given when EMS arrived ~~and the patient~~ ~~was~~ Cardiac resuscitation prevented additional Dantrolene from being given until arrival at Delray Medical Center as each time the dose was to be given she went into asystole in the ambulance. I rode in the ambulance with an additional bottle to try to deliver the additional dose but was unsuccessful due to her cardiac status. Her temperature in the ambulance was supposedly 110 degrees F.

Upon arrival at the hospital her resuscitative care was turned over the ER physicians, Cardiology, Nephrology, Infectious Disease and Cardio-Thoracic Surgery for central line placement. Patient received the additional doses of Dantrolene at the hospital and was

resuscitated. Malignant Hyperthermia Hotline was contacted. After the initial dose of 10 vials (200mg) of Dantrolene and along with almost 1.5 hours of gastric and bladder ice water lavage her temperature came down to 97.0 degrees. She was not [REDACTED] with a potassium of 8. After about 2 hours of resuscitation the patient was transferred to the ICU maintaining her own blood pressure and heart rate. Patient was continued on Dantrolene as per the MH Hotline. She required pressors to maintain her blood pressure later in the day. These were discontinued in the late evening and she maintained her own pressure. From 2AM to 6 AM she went into asystole several times and was resuscitated. I arrived back in the ICU about 6 AM. Patient's family decided to remove life support once she was in an agonal rhythm and without a pulse at approximately 6:15 AM.

This narrative for the Adverse Incident report has been written to the best of my recollection of the events of March 21-22, 2008

Signed

  
Steven Schuster, MD, FACS

#### IV. A. Analysis

Malignant Hyperthermia with cardiac arrest

#### IV. B. Corrective Action

1. Accreditation by AAAASF in 2000 with most recent onsite inspection in December 2007
2. Become an inspector for AAAASF
3. Refresher ACLS course
4. Conduct annual ACLS drills
5. Contracting with independent Risk Management firm for past 10 years.
6. Review of the malignant hyperthermia literature and treatment and remain current with updated data.
7. Join MHAUS and become an advocate for membership in the society for all surgeons performing office surgery
8. Malignant hyperthermia drills every 3 years with expired Dantrolene to maintain proficiency.

Steven Schuster, MD, FACS



**B) ICD-9-CM Codes**

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Code: 86.0-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
--	--	--

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure. ** If it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
---	---

Outcome of transfer - e.g., death, brain damage, observation only \_\_\_\_\_  
 Name of facility to which patient was transferred: CORAL GABLES HOSP

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

TRC 4  
RN  
MD - C. KAPLAN

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS / AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

PT [redacted]

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

Education - 111  
Charm Popper

**V. SIGNATURE (IF PHYSICIAN/LICENSEE SUBMITTING REPORT) LICENSE NUMBER**  
4/2/08 601314

**DATE REPORT COMPLETED TIME REPORT COMPLETED**



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

**DUPLICATE**

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office STEVEN SCHUSTER, MD, PA

Street Address 1905 Clint Moore Rd., #101

City BOCA RATON Zip Code 33496 County PALM BEACH

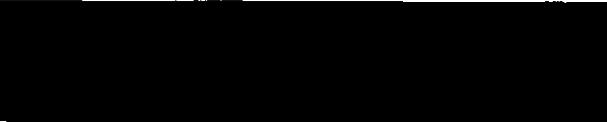
Telephone 561-912-9991

Name of Physician or Licensee Reporting STEVEN SCHUSTER, MD

License Number & office registration number, if applicable ME 48641 #308

Patient's address for Physician or Licensee Reporting SAME AS BELOW

II. PATIENT INFORMATION



Age 3.21.08 Gender Female Medicaid Medicare

Patient Identification Number HYPOMASTIA

Date of Office Visit Breast Biopsy taken Sargent

Diagnosis HYPOMASTIA

Purpose of Incident BIOPSY  
ICD-9 Code for description of incident 711  
Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

Incident Date and Time March 21 2008 9:35

Location of incident:  
 Operating Room  Recovery Room  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

SEE ATTACHED SHEETS

B) ICD-9-CM Codes

<u>V51.1 - Hypostasia</u>	<u>Malnutrition Hypertensive</u>	<u>Death</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstance, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident

(Use additional sheets as necessary for complete response)

Anesthesia Machine, Bovie Electrocautery, Post Monitor, AED

D) Outcome of Incident (Please check)

<input checked="" type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital. Outcome of transfer - e.g., death, brain damage, observation only <u>Death</u> Name of facility to which patient was transferred: <u>Delray Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure. ** If it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	---

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Steven Schuster MD - Plastic Surgeon HE 48641  
Dexter Weisbach, MD - Anesthesiologist HE 53287  
Sheryl Ledac, RN - Circulating Nurse RN 3203932  
Donna Randolph, - Scrub Tech

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Michelle Yaskovitz, RN RN 1523662

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

SEE ATTACHED SHEETS

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

SEE ATTACHED SHEETS

V. Steven Schuster MD HE 48641  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
4-2-08 10 PM  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

### III.A. Describe the circumstances of the incident (narrative)

██████████ was an ██████ year old ██████ who was referred to me by her mother for a breast augmentation. Her history was unremarkable and her mother had no history of anesthetic problems having recently undergone general anesthesia. She was desirous of a breast augmentation to become a full C cup. She also had inverted nipples as an aside which she wanted corrected at the same time if possible.

After a consultation and examination she was deemed an appropriate candidate for a breast augmentation using saline implants. She was offered the option of surgery in the office, surgicenter or hospital and chose to have surgery in the office setting. Surgery was scheduled for the following Friday March 21, 2008 at 7:30AM

██████████ underwent pre-op education and routine blood work about a week prior to surgery, which was found to be normal. Her pre-op booklet was reviewed with her and she had ample time to ask questions of both my nurse and myself at that meeting. She said she had no further questions and was ready to proceed.

On the morning of surgery she met with Dr. Peter Warheit, her anesthesiologist for this case. History was obtained from ██████ with her mother present and no anesthetic complications were known. Father was not available and when ██████ (mother) was queried about his anesthetic history she did not know of any problems in the past with anesthesia.

After induction of anesthesia by Peter Warheit, MD the patient was prepped and draped in the usual manner. Time out was performed for a breast augmentation and possible correction of inverted nipples. Surgery proceeded uneventfully through the decision of which size implant to use by placing the patient in the semi-seated position. The patient was then placed back in the supine position. Dr. Warheit noted a change in the patient's status and after thorough evaluation felt that patient was rapidly developing malignant hyperthermia. I would estimate this time to be about 9:35 AM.

At that time the procedure was aborted and the incisions closed with staples as expeditiously as possible. Staff was instructed to obtain as much ice as possible and call EMS to obtain emergency transport to Delray Medical Center and start mixing Dantrolene. During the time between the call to EMS and their arrival the initial 3 bottles of Dantrolene were mixed and a new IV started as patient rapidly appeared vasoconstricted. While this was occurring Dr. Warheit supported and managed the cardio respiratory system. During this time patient developed an arrhythmia as diagnosed by Dr. Warheit and the AED was placed on the patient. The patient was shocked which put her into a sinus rhythm. When patient had stopped clenching down on the LMA the tube was changed to an endotracheal tube.

The first 2 bottles of Dantrolene had already been given and the third ready to be given when EMS arrived and she went into asystole. Cardiac resuscitation prevented additional Dantrolene from being given until arrival at Delray Medical Center as each time the dose was to be given she went into asystole in the ambulance. I rode in the ambulance with an additional bottle to try to deliver the additional dose but was unsuccessful due to her cardiac status. Her temperature in the ambulance was supposedly 110 degrees F.

Upon arrival at the hospital her resuscitative care was turned over the ER physicians, Cardiology, Nephrology, Infectious Disease and Cardio-Thoracic Surgery for central line placement. Patient received the additional doses of Dantrolene at the hospital and was



resuscitated. Malignant Hyperthermia Hotline was contacted. After the initial dose of 10 vials (200mg) of Dantrolene and along with almost 1.5 hours of gastric and bladder ice water lavage her temperature came down to 97.0 degrees. She was noted to be in D.J.C. in the ER with a potassium of 8. After about 2 hours of resuscitation the patient was transferred to the ICU maintaining her own blood pressure and heart rate. Patient was continued on Dantrolene as per the MH Hotline. She required pressors to maintain her blood pressure later in the day. These were discontinued in the late evening and she maintained her own pressure. From 2AM to 6 AM she went into asystole several times and was resuscitated. I arrived back in the ICU about 6 AM. Patient's family decided to remove life support once she was in an agonal rhythm and without a pulse at approximately 6:15 AM.

This narrative for the Adverse Incident report has been written to the best of my recollection of the events of March 21-22, 2008

Signed

  
Steven Schuster, MD, FACS

#### IV. A. Analysis

Malignant Hyperthermia with cardiac arrest

#### IV. B. Corrective Action

1. Accreditation by AAAASF in 2000 with most recent onsite inspection in December 2007
2. Become an inspector for AAAASF
3. Refresher ACLS course
4. Conduct annual ACLS drills
5. Contracting with independent Risk Management firm for past 10 years.
6. Review of the malignant hyperthermia literature and treatment and remain current with updated data.
7. Join MHAUS and become an advocate for membership in the society for all surgeons performing office surgery
8. Malignant hyperthermia drills every 3 years with expired Dantrolene to maintain proficiency.

Steven Schuster, MD, FACS



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C78  
Tallahassee, Florida 32308-3276

?

**I. OFFICE INFORMATION**  
Name of office: Palms Institute of North Florida  
City: Tallahassee Zip Code: 32308 County: Leon  
Name of Physician or Licensee Reporting: George J. Arcos DO

Street Address: 2770 Capital Medical Blvd  
Telephone: 850-878-7246  
License Number & office registration number, if applicable: 57E 100  
05-4651

Patient's address for Physician or Licensee Reporting

**II. PATIENT INFORMATION**  
Patients Being Identified  
Patient Name: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_  
Patient Identification Number: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Medicaid:  Medicare:   
Date of Office Visit: \_\_\_\_\_  
Purpose of Office Visit: \_\_\_\_\_  
ICD-9 Code for description of incident: \_\_\_\_\_  
Level of Surgery (I) or (II): \_\_\_\_\_

RECEIVED  
CONSUMER SERVICES UNIT  
08 APR - 4 AM 7:02

**III. INCIDENT INFORMATION**  
Incident Date and Time: 3/23/08

Location of Incident:  
 Operating Room  Recovery Room  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

3/28/08 Suspicious cluster of staph aureus after RActive pain management

B) ICD-9-CM Codes

27096  
64483

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-89.9)

Under Investigation  
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)

Staph aureus abscess  
Resulting Injury (ICD-9 Codes 800-899.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response)

Fluoroscopic Chair; Sterile Needles

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.
<input type="checkbox"/> Surgical procedure performed on the wrong patient.	** If it resulted in:
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure.	<input type="checkbox"/> Death
<input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.	<input type="checkbox"/> Brain Damage
Outcome of transfer -- e.g., death, brain damage, observation only	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred:	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function.
	<input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.

Antibiotics; Irrigation/Debridement of Abscess

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

MA; 528191; Debra R. McGarvey Certified  
Charolee Beck LPN RN 5180575

F) List witnesses, including license numbers if licensed, and locating information if not listed above

N/A

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Robotic arm movement; ~~malfunction~~ primary Kanaly

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Contracted Dept. of Health. Closed responsible OR; <sup>Contracted</sup> all patients.  
Pulled all mayo to stock - sent for cultures to both / CDC.

v. Leona Lewis 054651  
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
4/2/08 0500  
DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bldg C75  
Tallahassee, Florida 32309-3275

I. OFFICE INFORMATION

Name of office: Space Coast Cancer Centers  
City: Rockledge Zip Code: 32965 County: Brevard  
Name of Physician or Licensee Reporting: Katie Wilkinson ARNP

Street Address: 8460 Executive Lane  
Telephone: (321) 453-1361  
License Number & office registration number, if applicable: ARNP 3073572

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

Date: March 7, 2008  
Purpose of Office Visit: [Redacted]  
ICD-9 Code for description of incident: [Redacted]  
Level of Surgery (II) or (III): [Redacted]

III. INCIDENT INFORMATION

Incident Date and Time: March 7, 2008 9:00 AM

Location of Incident:  
 Operating Rm.  Recovery Rm.  
 Other private office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(Use additional sheets as necessary for complete responses)

Waked into the office  
clo pain in back radiating down  
arms. was also hypotensive & diaphoretic.  
clo SOB, was also quite pale.  
pain started the night before, but  
chose not to go to the emergency room.  
With symptoms I felt it appropriate  
to call an ambulance for the patient.

RECEIVED  
CONSUMER SERVICES UNIT  
2008 MAR 21 AM 9:11

**B) ICD-9-CM Codes**

<u>n/a</u>	<u>n/a</u>	<u>n/a</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-89.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input checked="" type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer – e.g., <u>death</u> , brain damage, observation only Name of facility to which patient was transferred <u>Livesthaff Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Katie Wilkerson APRN 3073572

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

Marybeth Rosser, RN RN2031342

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

n/a pt presented to office extremely ill, tx to hospital add'l info available from Livesthaff Hospital. pt expired due to heart attack!

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

n/a

**V.** Katie Wiebe APRN 3073572  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
3/10/08 1600  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

RECEIVED  
CONSUMER SERVICES UNIT  
MAR 31 AM 9:40

### PHYSICIAN OFFICE ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Agency for Health Care Administration,  
Consumer Services Unit, Post Office Box 14000,  
Tallahassee, Florida 32317-4000

#### I. OFFICE INFORMATION

Watson Clinic  
Name of office  
Lakeland 33805 Polk  
City Zip Code County  
Karla F. Glotfelty  
Name of Physician or Licensee Reporting  
Watson Clinic  
Locating Information for Physician or Licensee Reporting

1600 Lakeland Hills Blvd.  
Street Address  
863 680-7000  
Telephone  
RN 2620102  
License Number

#### II. PATIENT INFORMATION

[Redacted]  
Patient Name  
[Redacted]  
Diagnosis

[Redacted]  
Age 3-4-08 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_  
Purpose of Office Visit  
593.9  
ICD-9 Code for Diagnosis

#### III. INCIDENT INFORMATION

3/4/08 12:05 pm  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other CT scan

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

#### A) Describe Circumstances of the incident (narrative) (use additional sheets as necessary for complete response)

PT was given 100cc Opti 320 for [redacted] abd.  
CAT SCAN. approx 8min later as I was  
getting [redacted] up after [redacted] scan was  
complete [redacted] was coughing - productive  
had been doing this prior to scan and said [redacted]  
was hot and just did not feel good. brought  
[redacted] out to the nurse to evaluate.

**B) ICD-9-CM Codes**

593.9

Q9967

518.81

5

~~799.1~~

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a licensed hospital	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Jody Harrison 5147485, Karla Klock 1614 RN 2620122  
Steve Paganella RT 3687, Dana Hall RN 1988717, Cindy O'Sken RN 1734782,  
Meghan Davis Sheldon RN 9217123, Erica Tripp RN 9214942, Kimberly Dean RN 3143572,  
Melissa Foley RT 57728, Tina Atkins RN 3209332, Wendy McGrain RT 37725,  
Janet Witkosky RRT 15288, Linda Bell RN 9174803, Joy Hackett RN 9270097  
Dr. Carol Chenole, Dr. Lawrence Bielecki 86271, Dr. Patricia Schmoedke ME 93255

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

As above

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

Solumedrol IV, Lasix IV, Respiratory support, transfer to hospital.

**V.**

Karl J. G. [Signature] 21620102  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
3/4/08  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

*copy of Q9967*



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

RECEIVED  
MAR 11 2008

Complaint Management Unit



I. OFFICE INFORMATION

Name of office: Oncology & Hematology Associates  
of West Broward

Street Address: 7431 NORTH UNIVERSITY DR. Suite 110

City: TAMPA Zip Code: 33321 County: BROWARD

Telephone: 954-726-0035

Name of Physician or Licensee Reporting: ENRIQUE DAVILA MD

License Number: ME 31035

Location Information for Physician or Licensee Reporting: Same

II. PATIENT INFORMATION



Age: 03/05/08 Gender: [REDACTED] Medicaid: [REDACTED] Medicare: [REDACTED]  
Date of Office Visit: [REDACTED]  
Purpose of Office Visit: chemo  
ICD-9 Code for Diagnosis: 202.80

RECEIVED  
COMPLAINT MANAGEMENT UNIT  
MAR 12 AM 11:15

III. INCIDENT INFORMATION

Incident Date and Time: 03/05/08 1530

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other chemotherapy infusion room

Note: If the incident involved a death, was the medical examiner notified?  Yes  No N/A  
Was an autopsy performed?  Yes  No N/A

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

0800 - Patient in for chemotherapy, received IV Decadron followed by w/ox 2000mg with  
Meana 200mg in 1L D<sub>5</sub> 1/2 NS over 4 hours. This completed @ 1305. Then infused with  
Meana 1000mg in 1L D<sub>5</sub> 1/2 NS over 2 hours which completed @ 1505. Etoposide  
180mg in 250cc NS began @ 1530, pt c/o "not feeling well". Infusion of chemo stopped  
containing NS KVO. Dr. Davila informed BP 170/100, P-76 O<sub>2</sub> SAT on R/A 95%.  
Pt c/o not feeling comfortable, hand movements flapping, unable to hold "STOP" position.  
Pt disconnected. Dr. Davila requested 911; EMT's called. Pt arriving 1mg IV ativan given  
as ordered, pt placed on O<sub>2</sub> -2L, Zomeprazole infusion began @ 1530. Bloodwork ordered @ 1540  
BP 150/100, pt disconnected to place (Hunks [REDACTED] @ NW Regional hospital) with attempt to  
stand + move to stretcher legs buckled - EMT's supported and lifted [REDACTED] to stretcher.  
Transported to UCH via ambulance.



**B) ICD-9-CM Codes**

chemo infusion 96413, 96415, 96417  
 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes D1-99.9)      Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)      Resulting injury (ICD-9 Codes 800-999.9)

**RECEIVED**  
**MAR 11 2008**

**C) List any equipment used if directly involved in the incident**  
 (Use additional sheets as necessary for complete response)      N/A

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure
<input type="checkbox"/> Surgical procedure performed on the wrong patient	** if it resulted in
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure	<input type="checkbox"/> Death
<input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a licensed hospital	<input type="checkbox"/> Brain Damage
	<input type="checkbox"/> Spinal Damage
	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function
	<input type="checkbox"/> Any condition that required the transfer of the patient

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Yajaira (Norma) Brey RN 1433692  
NANCY PELUSO RN 952582  
ENRIQUE DANILA MD ME031035

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

CHERYL DEWIA RN 9204298  
SUSAN RATHENBERG RN 1148592

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

LIKELY REACTIVE TO MEDICATION, AWAIT HOSPITAL RECORDS  
LIKELY T-EX INDUCED EXCEPTAION PAIN

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

Enrique Danila      ME031035  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER  
03/07/08      1500  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

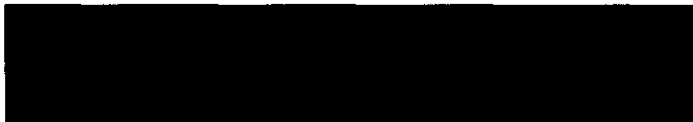


I. OFFICE INFORMATION

SALIENT MED CENTER  
Name of office  
LARGO 33770 Pinellas  
City Zip Code County  
BARBARA S. COUREN MD  
Name of Physician or Licensee Reporting  
Patient's address for Physician or Licensee Reporting

1601 W. Bay Dr.  
Street Address  
727. 674. 9990  
Telephone  
HCC 6761  
License Number & office registration number, if applicable

II. PATIENT INFORMATION



Age 3/6/08 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Purpose of Office Visit RECEIVE IV ORENOIN  
ICD-9 Code for description of incident \_\_\_\_\_  
Level of Surgery (II) or (III) \_\_\_\_\_

III. INCIDENT INFORMATION

3/5/08 2:35 PM  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other TREATMENT ROOM

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)  
PT with hx of receiving ORENOIN 100mg IV monthly - pre-  
MEDICATED always with Benadryl 50mg IV. within 10 min  
of pt starting to receive ORENOIN, pt itching -  
IV stopped w/s started. SOLU. Medrol 125mg given IV.  
PT c/o chest tightness, itching in throat, "lump" in throat,  
clearing throat. Physician notified Requested pt  
be sent to ER. call - pt to ER -> pt [redacted],  
symptoms eventually resolved. after 3hr, itching started  
again - in ER. treated & patient sent home

pt to flu with physician

RECEIVED  
CONSUMER SERVICES UNIT  
2008 MAR 1  
PM 3:07

**B) ICD-9-CM Codes**

*CPT 96413*

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

*ORUCIA*

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)

*995.2*

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital. Outcome of transfer - e.g., death, brain damage, (observation only) Name of facility to which patient was transferred: <u>LDIHO MEDICAL CENTER</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure. ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
---	---

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

NANCY WARD - PRIMARY NURSE - RN 832512  
CATHY O'GARA - ASSISTING WITH RESPONSE - RN 1057272

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

BARBARA COUSON RNLP 2916742

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

Apparently had allergic reaction to omeprazole

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

medication will be stopped by physician - or poss given again over more prolonged time

V. Barb. J. Couson RNLP 2916742  
**SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT** **LICENSE NUMBER**  
3/10/08 12/PM  
**DATE REPORT COMPLETED** **TIME REPORT COMPLETED**

4/10/08

#96

#190



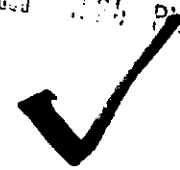
STATE OF FLORIDA  
Jeb Bush, Governor



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

CONSUMER SERVICES UNIT  
2008 APR 04 PM 2:59

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

Sarasota Interventional Radiology

Sarasota 34232-6410 Sarasota  
City Zip Code County

Dr. G. Grubbs



600 N. Cattlemen Road, Suite 100

(941) 578-3231

ME 63973

License Number & office registration number, if applicable

II. PATIENT INFORMATION



Age 4/10/2008 Gender Medicaid Medicare

Date of Office Visit

Purpose of Office Visit

Patient Identification Number  
[Blacked out]

ICD-9 Code for description of incident

Level of Surgery (I) or (III)

III. INCIDENT INFORMATION

4/10/2008 1330  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

In ~~the~~ patient became ~~nauseous and had increasing~~ dizziness. Patient had multiple episodes of ~~clear~~ clear mucus. Pt developed tremors and c/o being cold, pt did not complain of pain. Patients temperature checked with ear probe and temperature ~~to be~~ patients primary care physician, Dr. Imperio, contacted and orders taken to send patient to the emergency room at Sarasota Memorial Hospital. EMS contacted and patient sent via ambulance to Sarasota Memorial Hospital.

**B) ICD-9-CM Codes**

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

NA

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only <u>Admit to hospital</u> Name of facility to which patient was transferred <u>Sarasota Memorial Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
--	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Deborah Marvin Dr. Yard  
151 Altair Rd  
Venice, FL 34293  
RN # postop RN Anesthesiologist

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

Pt sent to hospital for analysis.

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

Sent to ER via ambulance.

**V.**

ME 63973

4-11-08 12:00pm  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED

900 North Callie Street  
Suite 100 - Access Center  
Sarasota, FL 34232-6410

941-378-3231  
941-378-3253 Fax  
www.sir.net



SARASOTA  
INTERVENTIONAL  
RADIOLOGY

*Immediate answers to critical questions.*

GERALD E. GRUBBS, MD  
Diplomate, American Board of Radiology  
Fellowship, Cardiovascular and Interventional Radiology

**PATIENT:** [REDACTED]  
**EXAM DATE:** 04/10/2008  
**PATIENT #:** [REDACTED]  
**DATE OF BIRTH:** [REDACTED]  
**REFERRING:** Dennis R Imperio, MD

Page 1 of 4

**EXAMINATION: ARTERIOVENOUS DIALYSIS FISTULOGAM, UPPER EXTREMITY VENOGRAM, AND SUPERIOR VENA CAVAGRAM; PHARMACOLOGIC DECLOTTING OF OCCLUDED ARTERIOVENOUS DIALYSIS GRAFT; ARTERIAL INFLOW AND VENOUS OUTFLOW ANGIOPLASTY**

**EXAM LOCATION: SARASOTA INTERVENTIONAL RADIOLOGY**

**INDICATIONS:** The patient with endstage renal disease on hemodialysis. The patient presented with clotted fistula for dialysis.

**PROCEDURE CODES:**

1. Arteriovenous dialysis fistulogram (36145/75790)
2. Second puncture in arteriovenous dialysis graft (36145)
3. Pharmacologic declotting of occluded fistula (36870)
4. Arterial inflow angioplasty (G0393/75962)
5. Extensive venous outflow angioplasty (G0393/75978)
6. Central venous angioplasty (35476/75978)
7. Post angioplasty venography.
8. Activase (J2997) - 4 mg
9. Versed (J2250) - 2 mg
10. Fentanyl (J3010) - 100 mcg
11. Lidocaine (J2001) - 5 cc
12. Nonionic contrast material (Q9949) - 50 cc
13. Saline solution (J2820) - 1000 cc
14. Heparin (J1644) - 3000 units.

**PROCEDURE:** After informed written consent was obtained, the patient was placed supine on the angio interventional table. Intravenous conscious sedation was given and monitored by Oasis Anesthesia Services throughout the procedure.

The left arm was sterilely prepped and draped in the standard fashion. 1% lidocaine was used for local anesthesia. A 22-gauge MicroStick needle was used to access the arteriovenous dialysis graft about 10 cm above the antecubital fossa with the needle tip directed back towards the arterial anastomosis. A 0.018-inch guidewire was advanced through the needle and the needle was removed. A 4 French sequential dilator was then advanced over the guidewire. The 0.018-inch

600 North Castlemen Road  
Suite 100 - Access Center  
Sarasota, FL 34232-8410

941-378-3231  
941-378-3253 Fax  
www.siv.net



SARASOTA  
INTERVENTIONAL  
RADIOLOGY

*Immediate answers to critical questions.*

GERALD E. GRUBBS, MD  
Diplomate, American Board of Radiology  
Fellowship, Cardiovascular and Interventional Radiology

**PATIENT:** [REDACTED]  
**EXAM DATE:** 04/10/2008  
**PATIENT #:** [REDACTED]  
**DATE OF BIRTH:** [REDACTED]  
**REFERRING:** Dennis R Imperio, MD

Page 2 of 4

guidewire was removed and the 0.035-inch glide wire was used to cross the arterial anastomosis, which proved extremely difficult. The catheter was advanced beyond the arterial anastomosis and hand injection with digital subtraction imaging did show a high-grade inflow stenosis.

A 6 French sheath was then advanced over the guidewire and through the sheath a 7 mm x 2 cm angioplasty balloon was advanced and arterial inflow angioplasty was performed.

The patient was then given a bolus at this point in time with 3000 units of heparin intravenously. 4 mg of tPA was also mixed per protocol and was then infused into the occluded graft.

A second puncture was then made in the graft closer to the arterial anastomosis this time with the needle tip directed towards the venous anastomosis. A 0.018-inch guidewire was advanced through the needle and the needle was removed. A 4 French sequential dilator was advanced over the guidewire. A 0.035-inch angled glide wire was used to cross the venous anastomosis and there was a high-grade stricture identified there as well. There was also subsequently noted to be a very high-grade central stenosis at the junction of the cephalic and axillary vein. This was an irregular long segment stenosis measuring over 3 to 4 cm. The central vein, including the subclavian, innominate, and superior vena cava were patent.

A 7 French sheath was then advanced over the guidewire and through this sheath an 8 mm x 4 cm angioplasty balloon was advanced. The venous anastomotic stenosis was dilated multiple different times and there was some recurrent spasm. Finally after three 3 minute long prolonged inflations the spasm was obliterated and the stenosis was partially alleviated. There was still a moderate residual stenosis in the 30% to 40% range.

The central stenosis responded better to balloon angioplasty. This was dilated to 8 mm as well and there was a good morphologic result at this site.

The arterial inflow balloon was then deflated. It was noted that the graft had been completely and successfully lysed and there was no residual thrombus identified. There was excellent flow identified through the graft at this point in time. There

600 North Cattlemen Road  
Suite 100 - Access Center  
Sarasota, FL 34232-6410

941-378-3231  
941-378-3263 Fax  
www.sivr.net



SARASOTA  
INTERVENTIONAL  
RADIOLOGY

*Immediate answers to critical questions.*

GERALD E. GRUBBS, MD  
Diplomate, American Board of Radiology  
Fellowship, Cardiovascular and Interventional Radiology

**PATIENT:** [REDACTED]  
**EXAM DATE:** 04/10/2008  
**PATIENT #:** [REDACTED]  
**DATE OF BIRTH:** [REDACTED]  
**REFERRING:** Dennis R Imperlo, MD

Page 3 of 4

was still a residual 30% to 40% stenosis at the venous anastomosis, which had been refractory to balloon angioplasty as described above.

Both sheaths were then removed and hemostasis was achieved using figure-of-eight pursestring sutures.

The patient was then transferred to the recovery unit where [REDACTED] was observed for an additional hour and a half. [REDACTED] transportation company was contacted to return [REDACTED] to [REDACTED] assisted care facility.

While [REDACTED] was in the recovery room [REDACTED] developed spontaneous bleeding from the puncture site from the dialysis center where [REDACTED] had been earlier in the day. Another pursestring suture was placed to control the bleeding.

Over the next 30 minutes, the patient was ~~complaining of generalized pain and~~ ~~pain~~ and began ~~developing a rigors indicating that some of the thrombus likely~~ ~~within the small pseudoaneurysms within [REDACTED] graft were chronic and the patient was~~ ~~bacteremic~~. The decision was made to urgently transfer the patient to the hospital.

**IMPRESSION:**

1. SUCCESSFUL PHARMACOLOGIC DECLOTTING OF AN OCCLUDED ARTERIOVENOUS DIALYSIS GRAFT AS DESCRIBED ABOVE.
2. SUCCESSFUL ARTERIAL INFLOW ANGIOPLASTY.
3. PARTIALLY SUCCESSFUL VENOUS OUTFLOW ANGIOPLASTY. THE CENTRAL STENOSIS WAS SUCCESSFULLY DILATED. HOWEVER, THERE WAS A VENOUS ANASTOMOTIC STENOSIS, WHICH WAS ONLY PARTIALLY ABLATED WITH BALLOON ANGIOPLASTY. WILL DISCUSS WITH VASCULAR SPECIALISTS OF SARASOTA ABOUT THE POSSIBILITY OF EITHER REVISING THE VENOUS ANASTOMOSIS OR THIS MAY REQUIRE CUTTING BALLOON ANGIOPLASTY OR POTENTIAL STENT PLACEMENT. PLEASE SEE DISCUSSION ABOVE.



600 North Cattlemen Road  
Suite 100 - Access Center  
Sarasota, FL 34232-6410

941-378-3231  
941-378-3253 Fax  
www.sivr.net



SARASOTA  
INTERVENTIONAL  
RADIOLOGY

*Immediate answers to critical questions.*

GERALD E. GRUBBS, MD  
Diplomate, American Board of Radiology  
Fellowship, Cardiovascular and Interventional Radiology

**PATIENT:** [REDACTED]  
**EXAM DATE:** 04/10/2008  
**PATIENT #:** [REDACTED]  
**DATE OF BIRTH:** [REDACTED]  
**REFERRING:** Dennis R Imperio, MD

**Page 4 of 4**

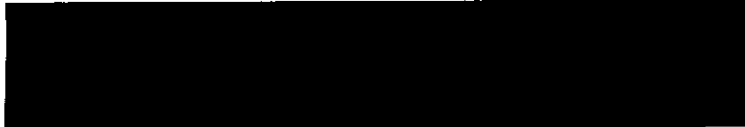
Thank you for allowing us to participate in the care of your patient here at Sarasota Interventional Radiology.

THIS REPORT WAS ELECTRONICALLY SIGNED  
**GERALD E. GRUBBS, M.D.**  
Board Certified Radiologist

GEG/ly/[REDACTED]  
DD: 04/15/2008 DT: 04/16/2008

4/24/08

#58



STATE OF FLORIDA  
Charlie Crist, Governor

RECEIVED  
2008 MAY 12 PM 2:10

FLORIDA DEPARTMENT OF  
**HEALTH**

# 39

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



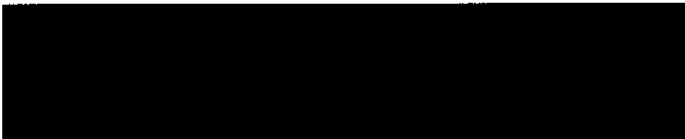
I. OFFICE INFORMATION

Watson Clinic LLP  
Name of office  
Lakeland 33805 Polk  
City Zip Code County  
John Bradshaw MD  
Name of Physician or Licensee Reporting

11600 Lakeland Hills Blvd  
Street Address  
863-680-7000  
Telephone  
NA  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 4/24/08 Gender Medical Medicare  
Purpose of Office Visit  
ICD-9 Code for description of incident  
Level of Surgery (II) or (III)

Patient Identification Number  
Diagnosis

III. INCIDENT INFORMATION

4/27/08  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other Hospital

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No Unknown

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Patient underwent [redacted] for clinical suspicion of cirrhosis and to rule out hepatocellular malignancy. Two days post biopsy patient presented to Emergency Department after experiencing [redacted] at which time 911 was called. CT of abdomen noted [redacted] consistent with [redacted]. Extensive discussions including hepatic [redacted] and [redacted] surgical consultation made. Though due to extensive underlying disease additional heroic measures were declined and patient subsequently [redacted] known complication of liver biopsy in .01-.02% of patients.

**B) ICD-9-CM Codes**

47000 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)      NA Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)      7982 Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

None

**D) Outcome of Incident (Please check)**

<input checked="" type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	<input type="checkbox"/> Surgical procedure performed on the wrong site** <input type="checkbox"/> Wrong surgical procedure performed** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	---

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

John Bradshaw MD, Radiologist ME 50635  
Cathy Tyson CT tech CRT 31437  
Wendy McGraw CT tech CRT 32225  
Michelle Bluhm CT tech CRT 14700

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

Patient experienced potential known complication of procedure.

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

Discharge instructions reviewed - symptoms of complications and interventions to take in response to those symptoms are available to patient.

v. [Signature] ME 50635  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER  
12:30pm  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED

4/28/08

#57

#191



#191

STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

PAUM BEACH PAW MGMT  
Name of office  
Lake Worth 33462 PAUM BEACH  
City Zip Code County  
MICHAEL SOBASKY D.O.  
Name of Physician or Licensee Reporting

3618 Lantana Rd #200  
Street Address  
561-968-2995  
Telephone  
NPI # 1629093596  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]  
Patient's Address  
Patient Identification Number  
Diagnosis

[Redacted]  
Age Gender Medicaid Medicare  
4-28-08  
Date of Office Visit  
Purpose of Office Visit  
ICD-9 Code for description of incident  
NA  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

4-28-08 @ 1042  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Checkouts

Note: If the incident involved a death, was the medical examiner notified?  Yes  No NA  
Was an autopsy performed?  Yes  No NA

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Pt was sitting in wheelchair waiting to make appt & became unresponsive. Taken to procedure room & placed on gurney. Vitals stable, given Narcan & became responsive to verbal stimulus. qil called, IV NS started 20g jclco Rt AC. Pt became drowsy, again gave Narcan & response - pt aroused to verbal stimulus. Pain Pump emptied and turned off. Pt transported to JFK hospital.

2008 MAY 12  
RECEIVED

**B) ICD-9-CM Codes**

NA

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer – e.g., death, brain damage, <u>observation only</u> Name of facility to which patient was transferred <u>JFK</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

MICHAEL SLOBASKY D.O. OS10005 - TREATING Physician  
LINDA BATTON RN RN9179232 - TREATING RN  
GEORGE TUTTLE MD ME92702  
CAROL NICHOLAS RN RN167457 - OFFICE MANAGER

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

potential leakage of narcotic medication from intrathecal pump.

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

dye study performed - pump turned off.

v. Carol Nicholas RN Office Mgr RN167457  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
4-28-08 1230pm  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

# PALM BEACH PAIN MANAGEMENT

□ 3618 Lantana Road - Suite 200  
Lake Worth, Florida 33462  
Tel: 561-968-2995 Fax: 561-968-0203

□ 4974 West Atlantic Boulevard  
Margate, FL 33063  
Tel: 954-972-2255 Fax: 954-968-3352

□ 5701 North Federal Highway  
Boca Raton, FL 33487  
Tel: 561-994-4522 Fax: 561-994-1203

## FOLLOW UP OFFICE VISIT

PATIENT NAME: [REDACTED]  
DATE OF SERVICE: 04/28/2008

**OFFICE VISIT:** The patient was seen on 04/28/2008 in regards to management of [REDACTED] multiple sclerosis, low back pain, and right buttock pain. The patient rated [REDACTED] pain a 6/10, down to a 2-3/10 with medications. The patient states that [REDACTED] has had low back pain with right buttock pain. The patient states [REDACTED] had debridement surgery on [REDACTED] right buttock decubitus ulcer yesterday. The patient states that since the surgery [REDACTED] has had increased pain with movement and ADLs. [REDACTED] denies any side effects from [REDACTED] current medications.

**PHYSICAL EXAMINATION:** In general, the patient is awake, alert and oriented x3, in no acute distress. [REDACTED] is responding appropriately to commands in [REDACTED] normal state of cognition. [REDACTED] buttock wound was evaluated and appeared intact. [REDACTED] abdominal exam reveals incision well-healed and no fluctuance. Rest of the physical exam is unchanged from previous visit.

**TREATMENT PLAN:** The patient was [REDACTED] The pump was refilled with 10 cc of a compounded medication concentration of Fentanyl 20,000 mcg/ml, Clonidine 1500 mcg/ml, Morphine Sulfate 30 mg/ml, and Ketamine 6 mg/ml. This concentration was infused after 2.9 ml was removed from the reservoir. [REDACTED] At 10:42 a.m., [REDACTED] the front desk in [REDACTED] The patient was wheeled into the procedure room and while [REDACTED] was being transferred to a gurney, the patient fell backwards in the wheelchair and hit [REDACTED] head on the floor. There was no blood or any discharge noted; however, there was [REDACTED] Ice was applied immediately to this region. Once on the gurney, a sternal rub was performed and [REDACTED] was somewhat responsive. Provider visit at 10:43 a.m. demonstrated blood pressure 156/93, heart rate 78, O2 saturation was 100%, and respiratory rate was 14 respirations per minute and regular. At 10:44 a.m., the patient was given 0.2 mg subcutaneously to the abdomen of Narcan. 911 was called. At 10:45 a.m., [REDACTED] blood pressure was 137/78, heart rate 79, SaO2 99% on room air, and respirations 16. Then, 0.2 mg of Narcan was given intravenously. Approximately two minutes after this, the patient did begin to respond and was awake, alert and oriented x3. At 10:50 a.m., EMR arrived. Blood pressure was 139/79, pulse 80, respirations 16, and SaO2 99%. The patient was placed on the monitor and transferred to the emergency medical response team's gurney. Prior to the patient being discharge with EMR, the pump reservoir was accessed using the template and a sterile technique. Approximately 8 cc of pink-tinged fluid was extracted from the reservoir. The pump was turned off at this point. The patient began to get lethargic again and was medicated with Narcan 0.4 mg intravenously. Again, the patient responded well to the Narcan and was alert and oriented x3. [REDACTED] was answering questions appropriately. [REDACTED] was present throughout this process. At 11 a.m., the patient was transferred with EMR to JFK Hospital. [REDACTED] was responding appropriately upon discharge from our clinic. Our plan will be to follow up at the emergency room with the patient regarding care.

██████████  
April 28, 2008

Page 2

There are a couple of etiologies for this recent ██████████. One may be the possibility that the diaphragm of the pump is inadequate, as when we inserted 10 ml during pump fill we only retrieved 8.5 ml. This is a 1.5 ml difference, which may be the culprit for the lethargy. Secondly, I would like to see the op report from ██████ surgery on Friday, which may demonstrate if there was any pump involvement. Another etiology of this lethargy may be that the patient has not been eating, drinking or sleeping very well since surgery and ██████ may be more sensitive to medications; however, this will be very coincidental in time with the pump fill. We will discuss with the emergency room regarding continued care and see the patient back for evaluation, at which time we will do a dye study to evaluate ██████ pump. We will see the patient back at this time.

---

Anthony Rogers, M.D., George Tuttle, M.D., Michael Slobasky, D.O.

AR:GT:MS:RKP:7093:D04/28/08:T04/29/08

Dictated but not proofread.



STATE OF FLORIDA  
Jeb Bush, Governor

RECEIVED  
CONSUMER SERVICES UNIT

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

2008 APR 30 PM 2:42

SUBMIT FORM TO:  
Agency for Health Care Administration,  
Consumer Services Unit, Post Office Box 14000,  
Tallahassee, Florida 32317-4000

? X

I. OFFICE INFORMATION

Southeastern Urological Center

Name of office

Tallahassee 32308 Leon

City

Zip Code

County

Deborah J Pettit ARNP

Name of Physician or Licensee Reporting

Same as above

Patient's address for Physician or Licensee Reporting

2000 Centre Pointe Blvd

Street Address

850-309-0400

Telephone

ARNP 1867392

License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

Age 4-28-08 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_

Date of Office Visit \_\_\_\_\_

Purpose of Office Visit NA

ICD-9 Code for description of incident NA

Level of Surgery (II) or (III) \_\_\_\_\_

Patient Identification Number \_\_\_\_\_  
Diagnosis \_\_\_\_\_

III. INCIDENT INFORMATION

4-28-08 @ 1130

Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other physicians office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Patient presents to be seen for post op/ office visit  
after [redacted] [redacted] [redacted]. Unrestful  
visit until waiting to be scheduled for surgery and  
then patient complained of [redacted]  
Vital signs stable, O<sub>2</sub> @ 2L began via nasal cannula.  
EMS notified for transport to hospital of patient's choice  
(TMM). Report given upon their arrival and  
transfer completed without incident.



**B) ICD-9-CM Codes**

<i>NR</i>	<i>NA</i>	<i>NA</i>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred: _____	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
--	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

*Patricia Gibson Johnson RN - RN 2519082 assisting patient during transport*  
*Deborah Pettit ARNP ARNP 1867392 practitioner seeing patient and ordering transport*  
*Jane Cooper (No license) front desk staff reporting patient chest pain to nurse staff*

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

*Unknown reason for patient's complaint of chest pain. Further evaluation needed.*

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

*No further action needed. Appropriate transport.*

**V.**

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

RECEIVED  
CONSUMER SERVICES UNIT

2008 MAY -7 AM 9:44

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

SPACE COAST CANCER CENTER  
Name of office  
Merritt Island 32952 Brevard  
City Zip Code County  
SEYMOUR ZIMM M.D.  
Name of Physician or Licensee Reporting

225 ONE RD  
Street Address  
321-453-1361  
Telephone  
NEEDS 024  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]  
Age 4/25/08  
Date of Office Visit Hospital Follow up  
ICD-9 Code for description of Incident 287.5  
Level of Surgery (II) or (III) n/a

III. INCIDENT INFORMATION

4/25/08 4PM  
Incident Date and Time  
Location of Incident:  
 Operating Rm  Recovery Rm  
 Other EXAM ROOM

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Pt & [redacted] were waiting in exam room for visit with physician. [redacted] came out from room & asked for help. [redacted] claimed pt did not respond verbally to [redacted] for a moment. When MA + RN came to pt [redacted] was responding. When arrived at office pt was [redacted] p 58. At time of incident 109/47, p 47, pulse ox 96%. Per Dr Zimm, ambulance was called.





STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

Name of office: Access Diagnostics  
City: Venice Zip Code: 34292 County: Sarasota

Street Address: 842 Sunset Lake Blvd, Ste 301  
Telephone: 941-441-0060

Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted patient information]

Age: 4/14/08 Gender: [Redacted] Medicaid: [Redacted] Medicare: [Redacted]  
Date of Birth: [Redacted]  
Purpose of Office Visit: 70553  
ICD-9 Code for description of incident: [Redacted]  
Level of Surgery (II) or (III): [Redacted]

III. INCIDENT INFORMATION

Incident Date and Time: 4/14/08 5:55 p.m.

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other: BIET room

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

During ~~the~~ study of the brain patient had  
seizure. 911 was called to transport patient  
to hospital for further evaluation.

RECEIVED  
CONSUMER SERVICES  
2008 APR 23 PM 2:15

B) ICD-9-CM Codes

70553

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only <u>observation, CT, labs</u> Name of facility to which patient was transferred <u>Venice Regional Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
--	--

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Holly Walters - MRI tech

Charissa Fowler - office manager

Denise Vazquez - office staff member

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME34421  
LICENSE NUMBER

4/15/08  
DATE REPORT COMPLETED

5:00pm  
TIME REPORT COMPLETED



**PATIENT:** [REDACTED]  
**EXAM DATE:** 04/14/2008  
**PATIENT #:** [REDACTED]  
**DATE OF BIRTH:** [REDACTED]  
**PHYSICIAN:** TRENT MASCOLA, D.O.

Page 1 of 2

**EXAMINATION: MRI OF THE BRAIN WITHOUT CONTRAST**

**EXAM LOCATION: VENICE**

**INDICATIONS:** Headaches; dizziness; seizures.

**FINDINGS:**

I was called last evening about this patient who was able to perform only 4 sequences, 1 of which is a scout view. Patient may have had a seizure on the table. The EMT was called. I spoke with the ER physician at the Venice Hospital emergency room after dialing 483-7000. I did not write down the name of the physician with whom I spoke. I gave him the following results:

*Sagittal T1-weighted images exhibit left hemispheric encephalomalacia involving the left temporal and frontal lobes. There is no evidence of an acute process on the sagittal images. Corpus callosum, brainstem, vermis, cerebellar tonsils, chiasm, infundibulum and pituitary gland appear normal.*

*A long TR FLAIR sequence was performed that exhibited gliosis adjacent to the encephalomalacia. The encephalomalacia may be related to prior surgery or perhaps injury. It is associated with minimal shift to the midline compatible with focal absence of brain. This shift may not be considered an acute pathologic process.*

There are no indications of hemorrhage, extracerebral collection, infarct or potential mass. Paranasal sinuses are remarkable for a small mucous retention cyst in the left maxillary sinus at the base of the sinus. Temporal bones exhibit appropriate signal void.

**IMPRESSION:**

1. This is a limited examination due to patient's inability to finish the study. Left hemispheric encephalomalacia may be postoperative or posttrauma and is associated with gliosis and mild chronic shift to the midline.
2. There is no definitive acute process.

5101 4<sup>th</sup> Avenue Circle East,  
Suite 100  
Bradenton, FL 34208  
Phone (941) 782-0414  
Fax (941) 782-0418

842 Sunset Lake Boulevard  
Suite 301  
Venice, FL 34292  
Phone (941) 441-0060  
Fax (941) 441-0070

600 North Cattlemen Rd.  
Suite 100  
Sarasota, FL 34232  
Phone (941) 342-0505  
Fax (941) 487-5800



PATIENT: [REDACTED]  
EXAM DATE: 04/14/2008  
PATIENT #: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PHYSICIAN: TRENT MASCOLA, D.O.

Page 2 of 2

Thank you for allowing us to participate in the care of your patient.

THIS REPORT WAS ELECTRONICALLY SIGNED  
PAUL J. MACCHI, M.D.  
Board Certified Radiologist

FI

RJM/[REDACTED]  
DD: 04/15/2008 OT: 04/15/2008

5101 4<sup>th</sup> Avenue Circle East,  
Suite 100  
Bradenton, FL 34208  
Phone (941) 782-0414  
Fax (941) 782-0418

842 Sunset Lake Boulevard  
Suite 301  
Venice, FL 34282  
Phone (941) 441-0598  
Fax (941) 441-0070

600 North Cattlemen Rd.  
Suite 100  
Sarasota, FL 34232  
Phone (941) 542-0506  
Fax (941) 487-5800



RECEIVED  
SERVICES UNIT  
22 APR 9:25

STATE OF FLORIDA  
Jeb Bush, Governor

PRACTITIONER REGULATION  
LEGAL

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT APR 21 PM 3:20

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

HEMATOLOGY ONCOLOGY CONSULTANTS  
Name of office  
Tampa City 33606 Zip Code Hillsborough County  
ELLEN R. SMILEY RN  
Name of Physician or Licensee Reporting

2111 SWANN AVE #102  
Street Address  
(813) 254-7227  
Telephone  
59-1674575  
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted Patient Information]

Age 4-16-08 Gender [Redacted] Medicaid Medicare  
Date [Redacted]  
Purpose of Office Visit [Redacted]  
ICD-9 Code for description of incident NA  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

4-16-08 1525  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other CLINIC

Note: If the incident involved a death, was the medical examiner notified?  Yes  No NA  
Was an autopsy performed?  Yes  No NA

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Patient receiving Rituximab infusion. Premedicated with Benadryl and Solumedrol per protocol. After receiving 450 mg of 750 mg dose, patient c/o shortness of breath & chest tightness. Infusion stopped Benadryl & Solumedrol administered IV. Pt c/o nausea, Zofran administered IV. Pt assessed by Dr. Stephens. Lungs clear, & Wheezing & Rales. O2 96% Room Air O2 Applied 2L per NC. Pt hydrated & NS @ KVD VS Monitored. Heart Rate ↑ Pt c/o chest tightness. EMS Activated. Taken to Memorial Hospital ER via ambulance. Pt stable at discharge.



B) ICD-9-CM Codes

Rituximab Injection  
Surgical, diagnostic, or treatment procedure being performed at time of incident  
(ICD-9 Codes 01-99.9)

Reaction to Rituximab  
Accident, event, circumstances, or specific agent that caused the injury or event.  
(ICD-9 E-Code)

↑HR SHORTNESS OF BREATH  
Resulting injury  
(ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident  
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred: <u>To MEMORIAL</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, visual, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient:
--	---

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Pam JAMES, RN ATTENDING NURSE  
ELLEN SMILEY RN ATTENDING NURSE  
ADRIA STEPHENS MD

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Reaction to Rituximab

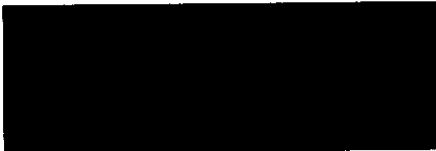
B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Benadryl & Solu-medrol administered. O2 5L per NC applied  
Patient transported to Memorial Hospital ER via ambulance

v. Adria N. Stephens MD ME 87796  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
4-16-08 14045  
 DATE REPORT COMPLETED TIME REPORT COMPLETED  
Ellen Smiley, RN  
2822572



STATE OF FLORIDA  
Job Bush, Governor



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

X

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4652 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32309-3275

I. OFFICE INFORMATION

Name of office: Space Coast Cancer Centers  
City: Titusville Zip Code: 32796 County: Brevard  
Name of Physician or Licensee Reporting: Kimberly K. Buckner, MD  
Patient's address for Physician or Licensee Reporting: \_\_\_\_\_

Street Address: 490 N Washington Ave  
Telephone: 321-268-4200  
License Number & office registration number, if applicable: RN 9170156

II. PATIENT INFORMATION

[Redacted Patient Information]

Age: 4-3-2008  
Date of Admission: \_\_\_\_\_  
Purpose of Office Visit: \_\_\_\_\_  
ICD-9 Code for description of incident: \_\_\_\_\_  
Level of Surgery (I) or (II): \_\_\_\_\_

III. INCIDENT INFORMATION

Incident Date and Time: 4-3-2008

Location of Incident:  
 Operating Room  Recovery Room  
 Other Medical Assistant Station

Note: If the incident involved a death, was the medical examiner notified?  Yes  No N/A  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets if necessary for complete response)

[Redacted] in office for [Redacted] along with weekly lab work. During RN evaluation, pt reports dizziness for 24-48 hours, not eating or drinking. Pt c/o N/V unrelieved by Phenergan. During lab draw pt reports feeling dizzy. I immediately called for Terry, MA for assistance. Pt fainted @ 1040. Pt lowered to the floor, legs elevated above heart, after 1.5 min pt awoke & awake, oriented x 3. O2 applied, VS stable, MD/ANP started, Dr Dulal called, Slt called, pt transported to ER.

RK

RECEIVED  
ORGANIZATION OF MEDICAL PROFESSIONS  
2008 APR 21 AM 9:14

**B) ICD-9-CM Codes**

30415 Blood draw

Surgical, diagnostic, or treatment procedure being performed at time of incident  
(ICD-9 Codes 81-89.9)

Accident, event, circumstances, or specific agent that caused the injury or event.  
(ICD-9 E-Codes)

Resulting injury  
(ICD-9 Codes 800-899.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

n/a

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar
Outcome of transfer - e.g., death, brain damage, observation only <u>observation</u> Name of facility to which patient was transferred <u>Parish Medical Center</u>	<input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Kimberly Buckner, RN RN 9170156

~~Kathy Witherspoon ARNP~~

~~Dr Richard Levine~~

~~Dr Garmine Glaine~~

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

Hatic Wilkerson ARNP, Terry Holmes, MA

Dr Richard Levine

Dr Garmine Glaine

ME0040927

ME0078051

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

Syncope - unknown etiology

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

n/a

v.

[Signature]

40927

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

4/9/08  
DATE REPORT COMPLETED

6:50 pm  
TIME REPORT COMPLETED

5/6/08

#58

#192



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

CARDIOLOGY CONSULTANTS, PA  
Name of office

5151 N. 9th Ave. Suite 200  
Street Address

Pensacola 32504 ESCAMBIA  
City Zip Code County

850-857-1700  
Telephone

NANCY A Riddlebover, RN, Clin Director  
Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

Age 05-06-2008 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_

Date of Office Visit \_\_\_\_\_

Purpose of Office Visit 786.D9 AND 799.D2

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

05-06-2008  
Incident Date and Time

Location of Incident:  
 Operating Rm.  Recovery Rm.  
 Other Outpatient Cardiac Cath Lab

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See Attached

**B) ICD-9-CM Codes**

93526 - Right & Left Heart Cath 786.09 799.02 NONE  
 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)      Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)      Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
 (Use additional sheets as necessary for complete response)

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred <u>Saved Heart Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

E. James Fleischauer, M.D. F.A.C.C. License # ME 62199, Cathing MD, 5151 N. 9th Ave. Suite 200 Pensacola,  
Brenda Davis, RCIS Lic # 40785 - Scrub Tech DN Case - 5151 N. 9th Ave. Suite 200 Pensacola  
Tammie Turpin RTr - CRT # 42381 - Circulating Case - 5151 N. 9th Ave. Suite 200 Pensacola  
Ferrah Jenkins, RN - Lic # 333842 - Nurse DN Case - 5151 N. 9th Ave. Suite 200 Pensacola

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

\_\_\_\_\_  
 \_\_\_\_\_

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

See Attached

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

See Attached

V. Nancy A. Edlbauer) RN 73774-2  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      LICENSE NUMBER  
7-26-08 3:00 PM  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED

DOB: [REDACTED]

Incident Date: 05/06/2008

Page 1 of 1

Description of circumstances of the incident:

Patient was brought to the Cardiac Catheterization lab for Right and left heart catheterization with known mild aortic Stenosis and chest pain concerning for angina. Patient was extremely anxious prior to the procedure and was given 1 mg Versed and remained wide awake with oxygen saturation greater than 90%. A second dose of Versed 1 mg was given with oxygen saturation remained greater than 90%. Right heart catheterization was performed and patient was noted to [REDACTED] Respirations 28 per min. [REDACTED] maintained sinus rhythm throughout this period. [REDACTED] became [REDACTED] [REDACTED] blood pressure 80 systolic, Heart rate 47 bpm, apneic, O2 Sat. 70%, patient unarousable.

Analysis and Corrective Action:

A. Analysis (apparent cause) of this incident:

Near respiratory arrest with possible aspiration secondary most likely to obesity, hypoventilation as well as vagal episode. Discharged from hospital 05-08-08 with diagnosis of acute respiratory failure now completely resolved. No aspiration. Suspect all due to massive girth with restriction of diaphragm while supine in cath lab. Day of discharge: NSR. VSS. Few rales. Right groin OK. Aortic Stenosis mildly worsened but surgical intervention not needed at this time. Needs massive weight loss. Dietitian to see and start 800 calorie/day diet.

B. Corrective or proactive action(s) taken:

Versed was reversed with Romazicon 0.2 mg IV. Additional medications given: Atropine 0.5 mg IV times 2 doses. Neo-Syneprine 100 mcg IV times 2 doses. Zofran 4 mg IV. Ventilated with 100% Oxygen via ambu bag mask. IV Normal Saline wide open. Chest compression started. The emergency room physicians was called for potential intubation but with opening the airway and moving [REDACTED] tongue, oxygen saturation gradually improved. An oral airway was placed and was 100% oxygen via oxygen mask. [REDACTED] oxygen saturation rose and the patient became fully conscious. However, the patient remained very agitated and diaphoretic despite this. [REDACTED] pressures returned. The heart catheterization was aborted due to concern that the patient may have aspirated as there was suction of bilious material. Patient admitted to the ICU for observation. At no time did the patient lose pressure or pulse. Transient CPR was done during one period of bradycardia which responded to atropine. Patient was admitted to the ICU in conscious, stable condition with oxygen saturation greater than 90% and sinus rhythm. Pulmonary consultation obtained.

5/7/08

#59

*[Signature]*

TMC

#193

[Redacted]

3056303332

P. 1



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32389-3275

I. OFFICE INFORMATION

Name of office: MICHAEL SALTMAN, M.D. PA BAL HARBOUR DBA: PLASTIC SURGERY ASSOCIATES  
City: BAL HARBOUR Zip Code: 33154 County: MIAMI-DADE  
Name of Physician or Licensee Reporting: MICHAEL SALTMAN, M.D.  
Patient's address for Physician or Licensee Reporting: 9701 Collins Ave Suite L-1 BAL HARBOUR, FL 33154

Street Address: 9701 Collins Ave Suite L-1  
Telephone: (305) 861-8266  
License Number & office registration number, if applicable: 1134634 / 052 514

II. PATIENT INFORMATION

[Redacted]  
Patient Identification Number: [Redacted]  
Diagnosis: [Redacted]

Age: 57 Gender: Male Medicaid: Medicare  
Date of Office Visit: [Redacted]  
Purpose of Office Visit: 512.1  
ICD-9 Code for description of incident: 512.1  
Level of Surgery (I) or (II): Level III

III. INCIDENT INFORMATION

Incident Date and Time: 5/7/08 12:30 PM

Location of Incident:  
 Operating Room  Recovery Room  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No N/A  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

PATIENT UNDERWENT A ROUTINE BREAST AUGMENTATION.  
WHILE COMPLETING THE SURGERY [Redacted]  
[Redacted]  
[Redacted]  
THE PATIENT REMAINED HEMODYNAMICALLY STABLE THROUGHOUT THE SURGERY AND DURING THE RECOVERY ROOM CHAIR.  
IT WAS TRANSFERRED TO MOUNT SINAI MEDICAL CENTER FOR A POST-OPERATIVE CHEST X-RAY AND OBSERVANT OBSERVATION AS A PRECAUTION.  
THE PATIENT WAS TRANSFERRED TO MOUNT SINAI IN STABLE CONDITION WITH O2 AND SUPPLEMENTATION.

B) ICD-9-CM Codes

<u>85.24</u>	<del>150.1</del> <u>150.1 / 844.8</u>	<u>512.1</u>
Surgical, diagnostic or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response)

N/A

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer - e.g., death, brain damage, observation only <u>OBSERVATION ONLY</u> Name of facility to which patient was transferred: <u>MOORE STAIN MEDICAL CENTER</u> <u>MIAMI BEACH</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
---	---

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

MILWAU FALCOWAN, MD - MISSISSIPPI - SURGEON - TEL # (202) 761-6992  
BARRY MILLER, RN - ARIZONA - NURSING - TEL # (602) 673-1214  
JALOOD A. EL ALAM - FLORIDA - ANESTHESIOLOGIST - AMERICAN BEACH OF ORANGE AVENUE # 307-264  
STEWART STOUSS, MD - ARIZONA - ANESTHESIOLOGIST - TEL # (303) 923-0093 # 307-264  
# 307-1330  
# 3394

F) List witnesses, including license numbers if licensed, and locating information if not listed above

JOHN AS FALCOWAN - MD - ARIZONA - TEL # (303) 923-0093  
ALBA - ROSARIO - RN - ARIZONA - TEL # (303) 923-0093

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

NO-ONE TRIP TO ADVISORY TO VENDOR, WITH SMALL TEAM  
WHILE SURGERY

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

1. TEAM WAS INSTRUCTED INTERACTIVELY AND AWARED WITH SURGEON.  
2. PATIENT WAS TRANSFERRED TO HOSPITAL FOR POST-OPERATIVE CARE.

V. [Signature] 057409  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
5/9/09 9 AM  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



5/13/08

#60

#40



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bln C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

STRAAL RESJUVENATION  
Name of office  
Lauderhill, FL 33351 Broward  
City Zip Code County  
Paul M. Goldberg  
Name of Physician or Licensee Reporting

4300 N. UNIVERSITY DR. SUITE A-202  
Street Address  
(954) 749-3040  
Telephone  
N/A  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]  
Age 5-13-08 Gender             Medicaid  Medicare  
Date of Office Visit 6-20-08  
Purpose of Office Visit N/A  
ICD-9 Code for description of incident LEVEL 3  
Level of Surgery (II) or (III)           

III. INCIDENT INFORMATION

6/20/08 - 6/21/08 11:00pm - 1:00 am  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other Home

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

PLEASE ATTACHED

**B) ICD-9-CM Codes**

15823-50  
CPT 15828/15821-50

UNKNOWN

N/A

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

NONE

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  <b>** If it resulted in:</b> <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
---	--

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

LISA ANANA - SURGICAL TECH

STAYCIE BULLER - SURGICAL TECH

LINDA LIEBOWSKI - R.N. 918002

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

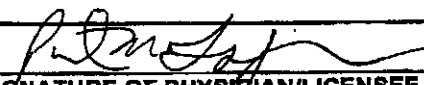
**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

SEE ATTACHED

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

SEE ATTACHED

V.  ME-93957  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
 07/03/08  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

It appears the patient died from natural causes and no corrective action is needed.

The patient was a [REDACTED] year old [REDACTED] who presented for facelift and eye surgery. Medical clearance was obtained and there were no contra indications to the scheduled procedures. On June 20, 2008 at Strax Rejuvenation and Aesthetics Institute, a face and neck lift, and upper and lower blepharoplasty's were completed by Paul Goldberg, M.D., under [REDACTED]. The surgery was uneventful except for a thirty second interval where the patients PO2 level fell to 65. A plastic mouthpiece was inserted to depress [REDACTED] tongue and pulled forward on [REDACTED] jaw, as this appeared to be related to [REDACTED] snoring, administered 1 mg of Narcan, I.V., and the PO2 came back up almost immediately.

The patient was in recovery for 80 - 90 minutes and was discharged fully awake, ambulatory, and went home with [REDACTED] daughter.

According to information from the family, the patient ate dinner at about 6:00 p.m., went to bed and was checked on by family members several times during the night until about 1:00 a.m. At that time they found [REDACTED] not snoring ([REDACTED] had been on the earlier occasions) and cold. EMT was called, [REDACTED] was transported to North Broward Medical Center and [REDACTED] pronounced [REDACTED] after some attempt at resuscitation.

The Medical Examiner performed an autopsy and concluded the patient died of a myocardial infarction, although the report has not been received.

5/15/08

FROM

(THU)MAY 22 2008 15:48/ST. 15:48/No. 7500000792 P 2

#194



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

PALM BEACH SPINE & PAIN INSTITUTE  
Name of office

2290 TENTH AVENUE N. #600  
Street Address

LAKE WORTH 33461 PALM BEACH  
City Zip Code County

561-649-8770  
Telephone

Dr. Douglas MacLean  
Name of Physician or Licensee Reporting

(053806) 594  
License Number & office registration number, if applicable

\_\_\_\_\_  
Physician's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

\_\_\_\_\_  
Patient Identification Number

\_\_\_\_\_  
Age 5-15-08 Gender Medical Record # 1040

\_\_\_\_\_  
Purpose of Office Visit

\_\_\_\_\_  
Diagnosis

\_\_\_\_\_  
ICD-9 Code for description of incident

\_\_\_\_\_  
Level of Surgery (II) or (III) (NEITHER)

III. INCIDENT INFORMATION

5/15/08 1010  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

(see attachment)

FROM

(THU)MAY 22 2008 15:50/ST. 15:49/No. 750000732 P 4

B) ICD-9-CM Codes

20610

NONE

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)

Resulting injury (ICD-9 Codes 800-899.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.
<input type="checkbox"/> Surgical procedure performed on the wrong patient.	
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure.	** if it resulted in:
<input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.	<input type="checkbox"/> Death
Outcomes of transfer - e.g., death, brain damage, observation only	<input type="checkbox"/> Brain Damage
Name of facility to which patient was transferred:	<input type="checkbox"/> Spinal Damage
JFK MEDICAL CENTER	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
DISCHARGED STABLE 5/16/08	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function.
	<input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

Douglas Mackay D.D. (053806) (Physician) ~~LAWRENCE GORFINE, MD (ME31792) (CAME FROM OFFICE PRACTICE 710 E TO AGENT)~~

Jeffrey Lewis RN (RN9208569) Recovery Nurse ~~CYNDI NEWMAN RN (RN2628402)~~

M. Kathleen Allaire (RN2146002) Recovery Nurse

Rosemary Porditman LPN (PN 411341) (Procedure Nurse) ALL LISTED CAN BE CONTACTED AT OUR FACILITY.

Charles Taylor RT (CA 33539) assisting physician

F) List witnesses, including license numbers if licensed, and locating information if not listed above (support staff)

ALL LISTED ABOVE.

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

[REDACTED]

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

N/A

V.

Do Mo-Len D.D. 053806  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
5/22/08 1600  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

FROM

(THU)MAY 22 2008 15:50/ST. 15:49/No. 750000732 P 3

**a) Describe circumstances of the incident (narrative)**

1010 Patient was received via stretcher to the post procedure area following a [REDACTED] injection under fluoroscopic view. The patient [REDACTED] At this time the patient was awake, alert and oriented X3(AAO X3). Vital signs were within normal range: Blood pressure 149/64, Heart rate 61, Respirations 16, and pulse oximetry 99%.

1015 Patient remained AAOX3. The heart rate was noted to suddenly decrease to 50 beats per minute. Electrode placement was checked and Dr. MacLear was notified. Patient denied ANY symptoms and remained AAO X3. IV was started in the left hand. IV NS was hung and infusion started. Oxygen was applied via nasal cannula at 3L. Patient's speech remained clear and [REDACTED] remained AA OX3. Dr. Gorfine at bedside as well.

1024 Blood pressure taken: 115 palpable, heart rate 40, pulse oximetry 100%. Patient remained AA OX3. Atropine given 0.4 mg IVP by Dr. Gorfine.

1025 Blood pressure 142/56, heart rate 48, pulse oximetry 100%.

1027 Atropine 0.1 mg IVP given by Dr. Gorfine. Call placed to 911. Heart rate 47, blood pressure 152/60, pulse oximetry 95%.

1030 Heart rate 60, pulse oximetry 100%. Patient remains AA OX3 without any complaints.

1032 Heart rate 52, pulse oximetry 100% with 3L O2 NC, blood pressure 120/62.

1035 [REDACTED] brought back to post procedure area to be with [REDACTED]

1037 Medics arrive. Call placed to JFK Medical Center ER triage to expect patient. (Dr. Gorfine had additionally placed call to Cardiologist, Dr. Michael Ray for consultation and referral).

1045 Patient transferred stable to JFK Medical Center via stretcher in ambulance.

**Addendum:**

It is our facility's policy to monitor ALL patients following ALL procedures done under fluoroscopy. Please note, this patient was NOT sedated and this was NOT a Level II procedure.

PALM BEACH SPINE AND PAIN INSTITUTE  
2290 Tenth Avenue North, #600  
Lake Worth, Florida 33461  
561-649-8770

5/16/08

#62  
#195



STATE OF FLORIDA  
Charlie Crist, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Cardiology Associates of Gainesville  
Name of office

4645 NW 8th Ave.  
Street Address

Gainesville 32605 Alachua  
City Zip Code County

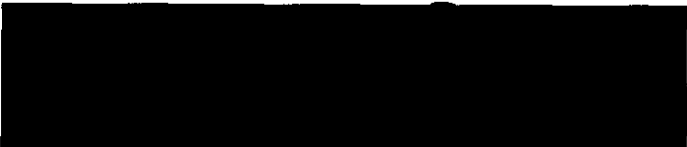
352/375-1212  
Telephone

Brian L. Werbel, MD  
Name of Physician or Licensee Reporting

ME 93739  
License Number & office registration number, if applicable

same  
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



chest pain, dyspnea  
Diagnosis

Age 5/16/08 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_

Date of Office Visit 5/16/08

Purpose of Office Visit N/A

ICD-9 Code for description of incident \_\_\_\_\_

Level of Surgery (II) or (III) II

III. INCIDENT INFORMATION

5/16/08 @ 1140  
Incident Date and Time

Location of Incident:  
 Operating Room  Recovery Room  
 Other PT Rm #4

Note: If the incident involved a death, was the medical examiner notified?  Yes  No N/A  
Was an autopsy performed?  Yes  No N/A

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See attached report: Cardiology Associates of Gainesville  
Incident Date: May 16, 2008

2008 MAY 23 PM 2:31  
RECEIVED  
CONSUMER SERVICES UNIT

**B) ICD-9-CM Codes**

786.50 786.09  
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

N/A  
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

N/A  
Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

Pt. monitoring - BP, Heart Monitor, SAO<sub>2</sub>

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.  Outcome of transfer - e.g., death, brain damage, observation only <u>pt dx on 5/16 @ 1724</u> Name of facility to which patient was transferred: <u>Shands ACH</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.  ** If it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
---	---

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

Brian L. Werbel, M.D - #93739/physician performing cath

Joanna L. Reynolds, CVT - cath lab staff

Derek R. Frazier, RCIS - 65787 cath lab staff

Marianne Thompson, RCIS 13818 - cath lab staff

Miranda Jensen, RN 9183748 - cath lab staff

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

Spouse - [redacted]; locating information same as patient's.

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

Unpredictable [redacted] [redacted]

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

None - this was an unpredictable event.

V. Brian Werbel MD #93739  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
5/27/08 Noon  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



Cardiology Associates of Gainesville  
Incident Date: May 16, 2008

On Friday, May 16, 2008, patient [REDACTED] underwent a left heart cardiac catheterization that was uneventful. The patient's vital signs were within normal limits and stable for the duration of the procedure. Approximately 2.5 hours post cath, CVT Joanna Reynolds was at the patient's bedside. The patient's post procedure recovery period had been uneventful and vital signs were stable, so Ms. Reynolds disconnected the patient from the monitoring leads and raised the head of [REDACTED] bed in preparation for lunch. Ms. Reynolds placed the call light on the patient's chest as she prepared to exit the room, at which time she noticed the patient's head slump back and [REDACTED] eyes rolled back. The patient was unresponsive to verbal or physical stimuli. Ms. Reynolds reconnected all monitoring equipment, returned the patient to the supine position, and immediately called for assistance.

CVT Derek Frazier, CVT Marianne Thompson, and RN Miranda Jensen were all within 25 feet of the patient room and they all responded immediately. Dr. Werbel was paged via the overhead paging system, as he was present in the building, but not in the area of the event. At this point the patient's vital signs all appeared to be stable and the patient appeared to awaken. [REDACTED] responded appropriately to questions and commands and was oriented to person and place. Dr. Werbel arrived at the patient's bedside and was updated on the event. Dr. Werbel felt that the patient had experienced a vasovagal event and elected to send the patient to Shands AGH as a precautionary measure.

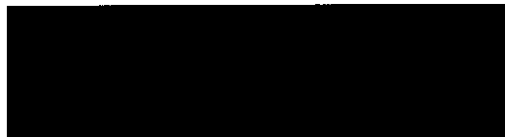
This duration of this event from the time the patient became unresponsive until [REDACTED] became awake and alert with the physician at [REDACTED] bedside was less than three minutes.

The patient was later discharged from the AGH emergency department after a period of observation. It was concluded that the patient had a severe vasovagal reaction.

5/18/07

463

#196



✓?



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
1052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

CARDIOLOGY CONSULTANTS, PA.  
Name of office  
DENVER CITY 32504 ESCAMBIA  
City Zip Code County  
NANCY A. RIDLENCOVER, R.N.  
Name of Physician or Licensee Reporting

5151 North 9th Ave Suite 200  
Street Address  
850-857-1700  
Telephone

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]  
Patient Identification Number  
BORDERLINE SEVERE AORTIC STENOSIS  
Diagnosis SEVERE CORONARY ARTERY DISEASE  
HYPERTENSION

[Redacted]  
Age 05-18-2007 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_  
Date of Office Visit  
RIGHT LEFT CARDIAC CATHETERIZATION  
Purpose of Office Visit 436  
ICD-9 Code for description of incident  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

05-18-2007 4:24 PM  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other CARDIAC CATH LAB

Note: If the incident involved a death, was the medical examiner notified?  Yes  No N/A  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Patient undergoing left & right heart catheterization, Coronary Angiography, Left internal mammary artery & saphenous vein bypass graft angiography and Aortic Root angiography. Just prior to the final vein graft angiograms, it was noted the patient had a fixed gaze to the left, with mild right facial weakness and weakness of the right upper extremity. Left pupil dilated react to light. Follows some commands.

B) ICD-9-CM Codes

<u>93826</u>	<u>436</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)
	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident  
(Use additional sheets as necessary for complete response)

NONE

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred <u>Sacred Heart Hospital, Pensacola</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

W. Daniel Doty, MD FACC FAHA ME # 31607, Catheter Physician - Phone 850-857-1700  
Jennifer Maltese, RN Lic # 3151692, Nursing Support, Phone - 850-857-1700  
Tammie Yurk, CVT Lic # 42381, Scrub / X-Ray, Phone - 850-857-1700  
Farah Jenkins, RN Lic # 3338432, Recorder, Phone - 850-857-1700  
Brenda Davis, RCIS Reg ID 00040785, Circulate, phone - 850-857-1700

F) List witnesses, including license numbers if licensed, and locating information if not listed above

As noted above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

This is a known and consented complication of a cardiac catheterization requiring patient transfer to a hospital facility.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

The procedure was quickly finished, catheters removed, right femoral arterial and venous sheaths sutured in place, urgent neurological consultation ordered & pt transferred to ICU.

v. Nancy A. Bullock, RN RN 737742  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
5-29-2007 10 AM  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

5/23/08

#197

#197



STATE OF FLORIDA  
Charlie Crist, Governor



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

To: 284

RECEIVED  
JUN 03 2008  
BY: *J. M.*

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION  
UM Reproductive Health.  
Name of office  
Miami 33136 Miami Dade.  
City Zip Code County  
Christopher Estes.  
Name of Physician or Licensee Reporting

1321 NW 14th St. # 201  
Street Address  
305-243-2984.  
Telephone  
OSR 557  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION  
[Redacted]

Age 5/23/08 Gender [Redacted] Medicaid Medicare  
Purpose of Office Visit 635.2  
ICD-9 Code for description of incident II  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION  
5/28/08 10:17 AM  
Incident Date and Time

Location of Incident:  
 Operating Room  
 Other Clinic  
 Recovery Room

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See attached

2008 JUN -3 PM 3:42  
BOARD OF MEDICINE

2008 JUN -3 PM 1:35  
RECEIVED

B) ICD-9-CM Codes

635

635.2

635.2

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident

(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital. Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input checked="" type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure. ** if it resulted in: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
--	--

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Describe the apparent cause of this incident (Use additional sheets as necessary for complete response)

~~Unlabeled equipment was used in procedure~~

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Quality assurance and improvement exercise with all staff involved, reviewed policies and documented activities

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

OCCURRENCE REPORT

(Please print all information legibly.)

Person Involved in Occurrence:

- Person Involved in Occurrence:
[X] Patient
[ ] Visitor
[ ] Employee
[ ] Contractual Employee

Name: [Redacted]

Address: [Redacted]

City, State, Zip: [Redacted]

Area Code, Phone Number: [Redacted]

S.S.#: [Redacted] Age: [Redacted] Sex: [Redacted]

Admitting Diagnosis: [Redacted]

Admission/Occurrence Date: 5/23/08 Time of Occurrence: 1017

Location of Incident: University of Miami OB/GYN - Suite 201W

Did injury occur? [X] Yes [ ] No [ ] Unknown

Nature of Injury: Uterine Perforation

Was Physician Notified? [X] Yes [ ] No If so, Date: 5/23/08 Time: 1017

Physician's Comments: Loop of bowel extruded through cervix, EMS called ER for pt notified. Pt taken to ER by EMS and Dr. Estes

- Type of Occurrence:
[ ] Slip/fall/found on floor
[ ] Witnessed [ ] Unwitnessed
[ ] Exposure incident
[ ] Procedure problem
[X] Surgical occurrence
[ ] Miscellaneous Occurrence:
[ ] Medication Error
[ ] Equipment-related problem
[ ] Theft/security problem
[ ] Property:
[ ] Damaged [ ] Missing
[ ] Other:

Description of Occurrence: Pt. had D&E at 17wks. uterine perforation occurred early in procedure - transferred to OR. Loop of bowel extruded uterine perforation and pt. ischemic to bowel. Bowel extruded into abdomen. Proceeded with [Redacted] and [Redacted]. Pt. admitted to UMH for further care.

\*\*\*\* DO NOT PHOTOCOPY \*\*\*\*

Name of Person(s) Involved/ Address/Telephone #:  
1. Christopher Estes, MD 1311 NW 14<sup>th</sup> St. Miami, FL  
2. Carla Lupi, MD (305) 293-2984 33136  
3.

Name of Person Preparing Report: Christopher Estes, MD

Date and Time Report Completed: 5/23/08, 5<sup>00</sup> p.m.

Date and Time Forwarded to the Administrator: 5/23/08 5<sup>00</sup> p.m.

Administrator's Signature: Scheremi

Comments:

Report must be forwarded to Risk Manager within 3 business days from the time of the occurrence. Serious incidents must be reported within 8 hours.

Date and Time Report Forwarded to Risk Manager: 5/27/08 14:00

Risk Manager's Signature: Lina Similien

Date Forwarded to Safety/Quality Assurance Committee:

Risk Manager/Committee Comments:

24-hour Report: Reportable to State Code 15 Report: Annual Report:

Two Digit Surgical Procedure Code: 69.0 Three Digit Resulting Injury Code: 863.50

E Code to Describe the Accident, event, circumstances, or agent that caused the injury or adverse incident: E810.0

Name of Personnel: ESTES CHRISTOPHER - ME0099617, Carla Lupi - ME53227.

Professional License # of SS# for Unlicensed Personnel: Lina Similien - ss# [redacted]

Relationship to the Facility: Employees. \*Martina Rivera - ss# [redacted]

\*\*\* DO NOT PHOTOCOPY \*\*\* #temp employee.





**B) ICD-9-CM Codes**

<u>757.9</u>	<u>E938.9</u>	<u>995.29</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.
<input type="checkbox"/> Surgical procedure performed on the wrong patient.	** if it resulted in:
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure.	<input type="checkbox"/> Death
<input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.	<input type="checkbox"/> Brain Damage
Outcome of transfer - e.g., death, brain damage, observation only <u>observation</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred: <u>Florida Medical Center</u>	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function.
	<input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.

**E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.**

Anire Okpaku, M.D.

Stacye Butler, M.A.

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

Medication reaction

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

This patient was stabilized, paramedics were called, and [redacted] was transported to Florida Medical Center for further care.

<b>V.</b> <u>[Signature]</u>	<u>ME36792</u>
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
<u>06-07-08</u>	<u>PM</u>
DATE REPORT COMPLETED	TIME REPORT COMPLETED

**PHYSICIAN OFFICE ADVERSE INCIDENT REPORT  
ADDENDUM**

**Circumstances of the incident:**

This [redacted] year-old, [redacted] lb. [redacted] with a strong penicillin allergy and history of hernia repair was prepared for breast augmentation surgery on the morning of May 23, 2008. This procedure was planned using a transaxillary, subpectoral approach.

This patient was given Valium 10 mg PO, Ativan 1 mg PO, Vicodin ES 1 PO, and Vancomycin antibiotics as preoperative medication. [redacted] was very anxious before surgery, so ~~Valium 10 mg PO~~ was given when the patient was being prepped for surgery. This procedure was done under ~~local anesthesia~~ using an equal part mixture of 50 cc. 1% Xylocaine with epinephrine 1:100,000, 50 cc. 0.5% Marcaine with epinephrine 1:200,000, and 50 cc. Normal Saline. This local anesthesia was carefully injected in a subcutaneous plane parallel to the chest wall in the breast and axilla. Less than 100 cc. of this anesthesia solution was used, which was well within the standard safe dosages for these drugs.

The procedure began with an incision in the right axillary crease. A submuscular implant pocket was elevated with blunt dissection from the clavicle to the inframammary fold. No bleeding or other difficulties were encountered during this process. The right breast was ready for antibiotic irrigation and placement of the saline breast prosthesis.

Before the right breast pocket was irrigated with antibiotic solution and the implant placed, this patient began to ~~become very agitated~~ and became very ~~agitated~~. It appeared that [redacted] may be having a medication reaction or a seizure. The surgery was stopped and oxygen and intravenous fluids were administered. Assistance was immediately requested from my office colleagues.

This patient then became hypotensive with a ~~blood pressure of approximately 80/50 and oxygen saturation dropped below 90%~~. [redacted] was treated with 10 mg of intravenous ~~Valium~~ and ~~Ativan~~. [redacted] was breathing poorly on [redacted] own, although breath sounds were intact. An endotracheal tube was placed and positive pressure ventilation was administered. [redacted] status greatly improved. In an effort to maintain stability, an additional 20 mg of intravenous Valium was given. The paramedics were called to transport this patient to Florida Medical Center for further evaluation and treatment.

[redacted] recovered well at Florida Medical Center and was sent home in 3 days. I saw this patient in my office in followup on May 27, 2008. [redacted] is doing well and may have [redacted] surgery done under general anesthesia in the future.



STATE OF FLORIDA  
Job Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bldg C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

Name of office: Space Coast Cancer Center  
City: Titusville FL Zip Code: 32796 County: Brevard  
Name of Physician or Licensee Reporting: Dr. Juan Castro  
Patient's address for Physician or Licensee Reporting: 490 N. Washington Ave Titusville FL 32796

Street Address: 490 N. Washington Ave  
Telephone: 321-268-4200  
73059  
License Number & office registration number, if applicable

II. PATIENT INFORMATION



Age: 51/2/08 Gender: \_\_\_\_\_ Medicaid: \_\_\_\_\_ Medicare: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Purpose of Office Visit: 276.51  
ICD-9 Code for description of incident: N/A  
Level of Surgery (I) or (III): \_\_\_\_\_

III. INCIDENT INFORMATION

Incident Date and Time: 5/2/08 2:00 pm

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other: Doctors office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Patient came in feeling [redacted]  
[redacted]. Vitals 98.4, 106, 115/72. M.D. notified IV fluids and heparin started. Approximate 30 min into fluids, pt experienced increase of SOB. Melissa Alexander RN checked sets and heart rate. HR 147. M.D. (Dr. Castro notified). Katie Wilkerson ARNP was notified. She advised pt to go directly to Emergency Room via ambulance. Emergency crew was notified via Narsel camera placed. Pt. transported to PMU via ambulance.

2008 MAY 29 PM 9:32  
RECEIVED

**B) ICD-9-CM Codes**

IV Fluids 2No.51

Surgical, diagnostic, or treatment procedure being performed at time of incident  
(ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event  
(ICD-9 E-Codes)

Resulting injury  
(ICD-9 Codes 800-899.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

B/p cuff O2 sets, IV fluids

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred <u>Farnett Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Katie Wilkerson, ARNP Melissa Alexander R.N. 9215092  
Dr Juan Castro 73059 Shelly Copeland R.N. 9225330  
Kim Buckner R.N. 9170156  
Barbara Ellis, R.N. 9251805

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

as above

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

Oxygen placed on pt because O2 sets were bad.  
IV fluid for dehydration.

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

Oxygen placed on pt because set were bad.

**V.**

[Signature]  
 SIGNATURE OF REPORTING LICENSEE SUBMITTING REPORT

73059  
 LICENSE NUMBER

3/20/03  
 DATE REPORT COMPLETED

TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Agency for Health Care Administration,  
Consumer Services Unit, Post Office Box 14000,  
Tallahassee, Florida 32317-4000



I. OFFICE INFORMATION

Southeastern Urological Center  
Name of office

2000 Centre Pointe Blvd  
Street Address

Tallahassee 32308 Leon  
City Zip Code County

850-309-0400  
Telephone

Burton B. Blasko MD  
Name of Physician or Licensee Reporting

1554842  
License Number & office registration number, if applicable

Same as above  
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 5-28-08 Gender Male Medicare Medicaid

[Redacted]  
Patient Identification Number

[Redacted]  
Date of Office Visit

[Redacted]  
Diagnosis

NA  
Purpose of Office Visit

NA  
ICD-9 Code for description of Incident

NA  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

5/28/08 @ 4:00 pm  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Physicians office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Patient presents as recent hospital discharge with low back pain. Has been on IV antibiotics x 4 days. Transient nausea, irritative breathing, infected pic line (which was to be removed in Nov 07). Symptomatic diabetic ketoacidosis with blood sugar greater than 600. Patient transferred to TMH for further treatment of neurologic symptoms and condition.

**B) ICD-9-CM Codes**

<i>NA</i>	<i>NA</i>	<i>NA</i>
Surgical diagnostic or treatment procedure being performed at time of incident (ICD-9 Codes 01-89.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

*(Use additional sheets as necessary for complete response)*

*NA*

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only <i>Admission for observation</i> Name of facility to which patient was transferred <i>TMH</i>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

<i>Byron Blacko R.D.P.</i>	<i>1554842</i>	<i>Practitioner providing care</i>
<i>Robert J. Bradford MD</i>	<i>ME 0065027</i>	<i>Supervising Physician</i>
<i>Shelley Keener R.D.</i>		<i>Supervising Endorager</i>

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (use additional sheets as necessary for complete response)**

*Patient presented with non-neurologic symptoms that were assessed by the practitioner and appropriately transferred to the hospital for follow up and treatment of conditions.*

**B) Describe corrective or proactive action(s) taken (use additional sheets as necessary for complete response)**

*Transfer appropriate*

V. *[Signature]*  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT      *915912*  
 DATE REPORT COMPLETED *5-29-08*      LICENSE NUMBER  
 TIME REPORT COMPLETED *1000*



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C78  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

SALIENT MEDICAL CTR  
Name of office  
Largo 35770 Pinellas  
City Zip Code County  
BARBARA J. COLEMAN ARNP  
Name of Physician or Licensee Reporting  
[Redacted]  
Patient's address for Physician or Licensee Reporting

1601 W. Bay Dr  
Street Address  
727.674.9920  
Telephone  
HCC6761  
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted]  
Patient Identification Number  
6270  
Diagnosis

[Redacted]  
Age Gender Medicaid Medicare  
5/19/08  
Date of Office Visit  
Purpose of Office visit  
9952  
ICD-9 Code for description  
Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

5/19/08 4:05p  
Incident Date and Time

Location of Incident:  
 Operating Rm.  Recovery Rm.  Other clinic

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

ABOVE PATIENT ORDERED 400mg Vancomycin IV q8 x 4 days  
This was dose #1. Discussed dose/rate with JMO  
Director. Agreed to dilute in 250cc NS + RUN in  
over 1hr. VITALS signs checked 3 x & REMAINED  
STABLE. AFTER IV DCA PT WENT TO bathroom -  
CAME BACK c/o [Redacted]  
itching & feeling of going to faint. PIV restarted -  
IVP Benzydol 50mg. IVP Saline 125mg. T.C.C  
ordering physician - Give epi. See SA stat.

1 of 2 pages PT came to emergency shaking, hives, gain, leg  
Form # DH-MQA1030- created 2-00; revised 3-24-03  
Example - T.C.C physician -  
Call 911 - sent to hospital for continued observation

**B) ICD-9-CM Codes**

CPT code

96413	Venofel	995.2
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred <u>Lane Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

2916742 BARBARA COURTEN ARNP - GAVE MEDS post infusion  
 1057292 CHRIS O'GARA RN - ASSISTED / hooked up w/d IV

STARTED PIV

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

N/A

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

DELAYED REACTION TO IV VENOFEL - Approximately 15 min after infusion complete, without ADV. REACTION DURING INFUSION.

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

Followed procedure to have pt stay 30" after new drug infusion

V. Barbara J Courten ARNP 2916742  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
5/28/03 5PM  
 DATE REPORT COMPLETED TIME REPORT COMPLETED





STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT



SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Cardiology Consultants, PA  
Name of office

1717 North "E" Street Suite 331  
Street Address

Pensacola 32501 Escambia  
City Zip Code County

850-444-1717  
Telephone

Nancy A. Biddehoover, RN Clinical Director  
Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

\_\_\_\_\_  
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

\_\_\_\_\_  
Patient Identification

Age 05-07-2008 Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_

\_\_\_\_\_  
Diagnosis

\_\_\_\_\_  
Date

\_\_\_\_\_  
Purpose of Office Visit

79d.31 and 79b.50  
ICD-9 Code for description of incident

\_\_\_\_\_  
Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

05-07-2008  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Diagnostic Treadmill Testing Area in Office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See Attached

B) ICD-9-CM Codes

784.65 - Nuclear Test  
J125D - Dehydration

Abn. EKG Chest Pain  
794.31 786.50

NONE

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident

(Use addit. or al sheets as necessary for complete response)

D) Outcome of incident (Please check)

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure
<input type="checkbox"/> Surgical procedure performed on the wrong patient	** if it resulted in
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure	<input type="checkbox"/> Death
<input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital	<input type="checkbox"/> Brain Damage
Outcome of transfer - e.g., death, brain damage, observation only	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred <u>Baptist Hospital</u>	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function;
	<input type="checkbox"/> Any condition that required the transfer outcome of the patient

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Robert H. Spencer, MD, F.A.C.C. NE #95966 Supervising MD - 1717 North "E" St. Suite 331  
Pamela Bush, RN Lic. # 3308937 - Nurse for Case - 1717 North "E" Street, Suite 331  
Kathleen Dawson, Med. Assistant - Stress Tech. Assistant/Coordinator - 1717 North "E" St. Suite 331  
Kendra Murrough, Med. Assistant - Stress Tech. RN Case - 1717 North "E" Street, Suite 331

F) List witnesses, including license numbers if licensed, and locating information if not listed above

No further

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

See Attached

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

See Attached

V.

Mary O. Bidloover RN 73774-2  
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
7-21-08 10:30 AM  
DATE REPORT COMPLETED TIME REPORT COMPLETED

DOB: [REDACTED]

Incident Date: May 7, 2008

Page 1 of 1

Description of circumstances of incident:

Patient having Dobutamine Nuclear Stress test for evaluation of increase in dyspnea on exertion consistent with angina. PMH positive for CAD with coronary stent placed in LAD and balloon angioplasty of diagonal branch in 09-2003.

Early in the stress test the patient developed some Wenckebach secondary degree I-A [REDACTED] developed at approximately peak stress and at a heart rate of 147 bpm, ST elevation in leads II, III AVF, V5, V6 and a little bit in V4. The ST segments worsened as symptoms worsened and then after the Lopressor and Nitroglycerin were administered the ST segment, at 11 minutes post stress, were nearly back to baseline and [REDACTED] chest pain resolved completely.

Analysis and Corrective Action

A. Analysis of this incident:

Past medical history of CAD and coronary intervention with recent symptoms of increasing DOE and Angina.

B. Corrective or proactive actions taken:

Lopressor and Nitroglycerin administered with resolution of [REDACTED] ST elevation and chest pain. Transferred to hospital for urgent Heart Cath and was found to have evidence of in-stent restenosis of [REDACTED] LAD. [REDACTED] had stenting with a drug-eluting stent within [REDACTED] LAD and angioplasty of [REDACTED] diagonal. [REDACTED] had no ongoing problems following this. Discharged home on 05-08-2008 with follow-up visit scheduled for one month.



**B) ICD-9-CM Codes**

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**

(Use additional sheets as necessary for complete response)

**D) Outcome of Incident (Please check)**

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred <u>Sarasota Memorial Hospital Lakewood Ranch</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
--	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Dr. Laura Yard ME 68224

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

**B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)**

V. L. Yard ME 68224  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
5/8/08 1520  
 DATE REPORT COMPLETED TIME REPORT COMPLETED

600 North Cattlemen Road  
Suite 100 - Access Center  
Sarasota, FL 34232-6410

941-378-3231  
941-378-3263 Fax  
www.sivr.net



**SARASOTA  
INTERVENTIONAL  
RADIOLOGY**  
*Immediate answers to critical questions.*

**GERALD E. GRUBBS, MD**  
Diplomate, American Board of Radiology  
Fellowship, Cardiovascular and Interventional Radiology

**PATIENT:** [REDACTED]  
**EXAM DATE:** 05/08/2008  
**PATIENT #:** [REDACTED]  
**DATE OF BIRTH:** [REDACTED]  
**REFERRING:** Scott A. Tetreault, MD

Page 1 of 2

**EXAMINATION: CT GUIDED DEEP BONE BIOPSY**

**EXAM LOCATION: Sarasota Interventional Radiology**

**INDICATIONS:** Patient with profound anemia.

**PROCEDURE CODES:**

1. Percutaneous bone biopsy (20225)
2. CT guidance for needle placement (77012)
3. Saline solution (J2820) - 500 cc

**ANESTHESIA:** Level II conscious sedation.

**ANESTHESIOLOGIST:** Dr. Yard

**PROCEDURE:** After informed written consent was obtained, the patient was placed prone on the CT Gantry table.

Localizing images were obtained through the lumbosacral spine. However, at that time an electrocardiogram tracing showed that the patient had ST segment depression. An old electrocardiogram was obtained from Dr. Albert's office and this was a new finding.

Due to this change which more than likely was due to the patient's profound anemia, the procedure was aborted as it was felt to be unsafe to give the patient intravenous conscious sedation in this setting.

Dr. Tetreault was notified and the patient's primary care physician was notified.

The patient was transferred to the hospital for transfusions. If [REDACTED] electrocardiogram normalizes, then we can proceed with bone marrow biopsy at that time.

600 North Cattlemen Road  
Suite 100 - Access Center  
Sarasota, FL 34232-6410

941-378-3231  
941-378-3253 Fax  
www.sivr.net



**SARASOTA  
INTERVENTIONAL  
RADIOLOGY**

*Immediate answers to critical questions.*

**GERALD E. GRUBBS, MD**  
Diplomate, American Board of Radiology  
Fellowship, Cardiovascular and Interventional Radiology

**PATIENT:** [REDACTED]  
**EXAM DATE:** 05/08/2008  
**PATIENT #:** [REDACTED]  
**DATE OF BIRTH:** [REDACTED]  
**REFERRING:** Scott A. Tetreault, MD

**Page 2 of 2**

Thank you for allowing us to participate in the care of your patient here at Sarasota Interventional Radiology.

**THIS REPORT WAS ELECTRONICALLY SIGNED**  
**GERALD E. GRUBBS, M.D.**  
Board Certified Radiologist

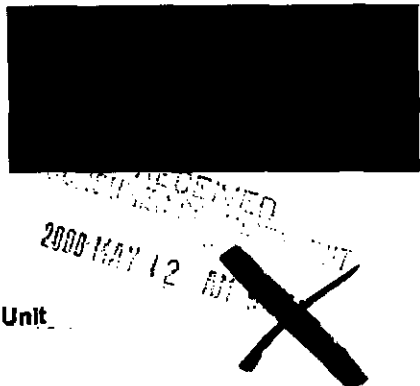
GEG/trw/[REDACTED]



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bln C75  
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

Name of office: Space Coast Medical Associates

City: Cocoa Beach Zip Code: 32931 County: Brevard

Name of Physician or Licensee Reporting: Dr Zimm

Street Address: 699 W. Cocoa Beach Cwy

Telephone: (321) 783-9544

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

Age: 5/1/08 Gender: Male Medicaid/Medicare

Date of Incident: 5/1/08

Purpose of Office Visit: [Redacted]

ICD-9 Code for description of Incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Incident Date and Time: 5/1/08 3:40 pm

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other MD office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No N/A

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

3:40pm Pt became [redacted] after Neuhata injection BP 72/48 HR 72 O<sub>2</sub> sat 95% on R/A Pt's port accessed & 1L NS started pt in reclining chair w/ feet elevated 3:45 BP 80/58 HR 76 skin w/d no further dizziness Dr Levine notified 4:30pm Dr Zimm in to assess pt. BP 80/54 1L NS infused 500 NS started due to continued low BP 5:10pm BP 80/60 pt more lethargic 911 called & pt transferred to ER / Dr Brewer MD



1) ICD-9-CM Codes

<u>injection</u>	<u>injection</u>	<u>n/a</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident  
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred <u>Cape Canaveral Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure  ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
--	--

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Dr Solomon Zimm MFE0050524  
Danielle Brewer RN RN1663542  
Melissa Page Chinn RN 9248257

F) List witnesses, including license numbers if licensed, and locating information if not listed above

as above

IV. ANALYSIS AND CORRECTIVE ACTION


A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Vagal response

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

n/a

V.

 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	<u>MFE0050524</u> LICENSE NUMBER
<u>5/2/08</u> DATE REPORT COMPLETED	<u>0900</u> TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

RE  
CONSUMER

2008 ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Agency for Health Care Administration,  
Consumer Services Unit, Post Office Box 14000,  
Tallahassee, Florida 32317-4000



I. OFFICE INFORMATION

Southeastern Urological Center  
Name of office

Tallahassee 32308 Leon  
City Zip Code County

Raleigh W. Raelin MD  
Name of Physician or Licensee Reporting

Same as above  
Patient's address for Physician or Licensee Reporting

2000 Centre Pointe Blvd  
Street Address

850-309-0400  
Telephone

ME 20010  
License Number & office registration number, if applicable

II. PATIENT INFORMATION



Age 5-9-08 Gender            Medicaid Medicare           

Date of Office Visit           

Patient Identification Number             
Diagnosis Abdominal pain & today  
No chest pain

Purpose of Office Visit             
ICD-9 Code for description of incident NA  
Level of Surgery (II) or (III) NA

III. INCIDENT INFORMATION

5/9/08 @ 1300  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Physicians Office

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

Presents for follow up visit for abdominal pain. Patient complains of chest pain and pain radiating down left arm. Vital signs stable. Oxygen initiated. Patient fully alert and responsive. Transported to TMH for further evaluation of a non urologic condition.

**B) ICD-9-CM Codes**

<u>NA</u>	<u>NA</u>	<u>NA</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital  Outcome of transfer - e.g., death, brain damage, observation only & assessment Name of facility to which patient was transferred <u>TNH</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
---	--

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

Raleigh H. Kallens MD ME20010 Care Provider  
Deborah J. Pettit ARNP ARNP1867392 case provider  
Ronda Cigales LPat PN454431 providing nursing care  
Patricia Labron Johnson RN RN2519082 Assisting with transport

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

No corrective action needed. Transport appropriate  
Low symptoms non urologic in nature. Patient  
needed evaluation of chest pain

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

None needed

[Signature] RN 915912  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
5-12-08 1230  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

# 266

triple  
bleed  
med nec

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bln C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Cardiology Consultants PA  
Name of office

1117 North "E" Street Suite 331  
Street Address

Pensacola 32501 Escambia  
City Zip Code County

850-444-1717  
Telephone

Nancy A. Riddleberger MD, Chandra Director  
Name of Physician or Licensee Reporting

NA  
License Number & office registration number, if applicable

NA  
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



60 [Redacted]  
Age Gender Medicaid/Medicare

Post Cardiac Catheterization, PEAD -  
Diagnosis peritoneal hematoma

06-23-2008  
Date of Office Visit

Cardiac Catheterization  
Purpose of Office Visit

998.12  
ICD-9 Code for description of incident

NA  
Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

06-23-2008 1:37 PM  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Outpatient Cath Lab

Note: If the incident involved a death, was the medical examiner notified?  Yes  No NA  
Was an autopsy performed?  Yes  No NA

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See Attached Narrative

B) ICD-9-CM Codes

93510-Left Heart Cath  
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

NONE  
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

998.12  
Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure
<input type="checkbox"/> Surgical procedure performed on the wrong patient	** if it resulted in
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure	<input type="checkbox"/> Death
<input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital	<input type="checkbox"/> Brain Damage
Outcome of transfer - e.g., death, brain damage, observation only <u>Discharge/Duty</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred <u>Baptist Hospital of Pensacola</u>	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function;
	<input type="checkbox"/> Any condition that required the transfer outcome of the patient

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Benjamin E. Lloyd, MD, ME 96896, Cathing Physician, 1717 N. E. Street, Ste 331, Pensacola  
Patricia Lytle, RTR - CAT # 33458, Radiology Tech/Scrub, 1717 N. E. Street, Ste 331, Pensacola  
Tina Pickett, RN - License # 9263229, Circulating Nurse, 1717 N. E. Street, Ste 331, Pensacola  
Linda Kuhnert, RN, License # 9176749, Recorder, 1717 N. E. Street, Ste 331, Pensacola  
Sylvia Wells, RN, License # 1210952, Nurse # 2

F) List witnesses, including license numbers if licensed, and locating information if not listed above

Listed Above  
Jennifer Mattese, RN, License # 3151693, Nurse # 1, 1717 N. E. Street, Ste 331, Pensacola

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

See Attached Narrative

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

See Attached Narrative

V. Manoj A. Pillay, MD 737752  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
1-12-09 8:50 AM  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



**Incident Date: 06-23-2008**

**Page 1 of 1**

**Description of circumstances of the incident:**

Patient underwent outpatient cardiac catheterization for new onset chest pain and borderline abnormal stress test. The patient tolerated cardiac catheterization fine during the procedure; however, after pulling the femoral sheath the patient started to complain of right lower quadrant abdominal discomfort. CT scan of abdomen and pelvis consistent with hematoma tracking up from the right inguinal region into the right retroperitoneum.

**Analysis and Corrective Action:**

**A) Analysis (apparent cause) of this incident:**

Known complication of cardiac catheterization.

**B) Description of corrective or proactive action(s) taken:**

Physician notified and examined patient. No hematoma or bleeding noted. Physician ordered patient to be admitted to the hospital for observation and CT Scan of Abdomen and Pelvis. Hemoglobin and hematocrit monitored. Patient discharged 06-28-08 with instructions to; 1) Avoid medications containing aspirin or aspirin-like products for at least a week, 2) No lifting heavier than 3 pounds for a least 1 week, 3) Follow up with Physician in one week and follow up hemogram with platelets on return, 4) Percocet 7.5/325 for pain as needed.

Follow up office visit on 07-03-08 shows Hemoglobin stable at 12.4 (Precatheterization hemoglobin was 12.5). Hematoma slowly improving. Continue pain management.

Follow up office visit on 07-07-08 reveals significant improvement in symptoms. Groin site well healed. Recommend another week of no heavy lifting and follow up prn.

6/5/08

#66



#41

STATE OF FLORIDA  
Jeb Bush, Governor



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bldg C75  
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office Center For Surgical Excellence

City St. Petersburg Zip Code 33710 County Pinellas

Name of Physician or Licensee Reporting Dr. Robert Rehnke

Street Address 66606 10th Ave. N.

Telephone 727-341-0337

License Number & office registration number, if applicable ME 55774

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

Age \_\_\_\_\_ Gender \_\_\_\_\_ Medicaid Medicare \_\_\_\_\_

Date of Office Visit Date of Surgery 6-5-08

Purpose of Office Visit [Redacted]

ICD-9 Code for description of Incident 798.1

Level of Surgery (I) or (II) or (III) (III)

III. INCIDENT INFORMATION

Incident Date and Time June 6, 2008

Location of Incident  
 Operating Rm  Recovery Rm  
 Other Home

Note: If the incident involved a death, was the medical examiner notified?  Yes  No (Medical examiner notified our office of pt's [Redacted])  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

(See attached timeline)

**B) ICD-9-CM Codes**

798.1

Surgical, diagnostic, or treatment procedure being performed at time of incident. (ICD-9 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)

Resulting injury (ICD-9 Codes 800-999.9)

**C) List any equipment used if directly involved in the incident**  
(Use additional sheets as necessary for complete response)

N/A

**D) Outcome of incident** (Please check)

<input checked="" type="checkbox"/> Death @ home	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure
<input type="checkbox"/> Surgical procedure performed on the wrong patient	** If it resulted in
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure	<input type="checkbox"/> Death
<input type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital	<input type="checkbox"/> Brain Damage
Outcome of transfer - e.g., death, brain damage, observation only _____	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred _____	<input type="checkbox"/> Permanent disfigurement not to include the inclusion scar
	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function;
	<input type="checkbox"/> Any condition that required the transfer outcome of the patient _____

**E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.**

N/A

**F) List witnesses, including license numbers if licensed, and locating information if not listed above**

(See attached timeline)

**IV. ANALYSIS AND CORRECTIVE ACTION**

**A) Analysis (apparent cause) of this incident** (Use additional sheets as necessary for complete response)

Autopsy pending

**B) Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

Chart reviewed, will report to AAAASF per protocol

**V.**

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME5574  
LICENSE NUMBER

6/11/08  
DATE REPORT COMPLETED

6p  
TIME REPORT COMPLETED



**Robert D. Rehnke, M.D.**

PATIENT:



DATE: 6/6/08

PATIENT NO:

**OPERATIVE REPORT**

PAGE 1

PREOPERATIVE DIAGNOSIS: Skin laxity and breast ptosis

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Bilateral brachioplasty and bilateral mastopexy

SURGEON: Robert D. Rehnke, M.D.

ANESTHESIA: A black rectangular redaction box covering the details of the anesthesia used.

ANESTHESIOLOGIST: Dr. Ramsey Nashad

COMPLICATIONS: None

ESTIMATED BLOOD LOSS: Minimal

IV FLUIDS: 1700 cc of lactated ringers

URINE OUTPUT: One liter

DRAINS: None

JUSTIFICATION: The patient is a -year-old who lost 110 lbs through Weight Watchers and presented complaining of sagging breasts and loose arms.

PROCEDURE: After informed consent and preoperative marking, was taken to the operating room for the above procedure. was placed on the OR table and underwent a general orotracheal anesthesia and had the arms, breast and chest prepped with Betadine and sterile towels and drapes. Tumescent fluid was injected to the surgery sites and the procedure was begun with a bilateral full mastopexy using a wise pattern skin pattern and a superior pedicle technique. After incising and de-epithelizing the keyhole, the dermis was divided below the areola and on each left and right sides of the vertical portion and horizontally of the mid section of the ellipse that was de-epithelized in the inframammary fold. Electrocautery was used to

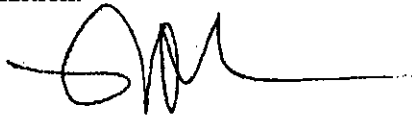
**Robert D. Rehnke, M.D.**

PATIENT: [REDACTED]

**OPERATIVE REPORT**

PAGE 2

dissect down the inframammary fold ligament to the retro glandular space and a small pocket was developed behind the breast. A 2-0 Ethibond suture was used to imbricate the medial and lateral pillars of breast tissue together and also used to reinforce the inframammary fold position. The tissue that was de-epithelized along the vertical portion was then imbricated and the dermis was approximated with the Ethibond sutures. This created a breast mound shape and the skin was then closed with 3-0 Vicryl sutures and 4-0 Monocryl subcuticular. The same steps were done on the contralateral breast. Next, the right arm was operated upon by first incising the ellipse of excess skin which had been marked preoperatively. This ran from just below the elbow along the inner brachial line and into the axilla. The electrocautery was used to divide through the subcutaneous fat and superficial fascia and the fat and skin was removed to the level of the interface between deep fascia and superficial fascia. Small perforating vessels were thoroughly cauterized with electrocautery and the sensory nerve was spared. The skin was removed and the flap was tacked together along the superficial fascia with interrupted 2-0 PDS sutures. The skin dermis was tacked loosely with interrupted 3-0 Vicryl sutures followed by a deep dermal 0 Quill suture followed by a 4-0 Monocryl subcuticular skin closure. The same exact steps were done on the contralateral left arm. The patient tolerated the procedure well and had sterile dressings placed and was extubated and sent to the recovery room awake and in stable condition.



Robert D. Rehnke, M.D.

RDR/blb

R: 6/6/08

T: 6/6/08

## SUMMARY OF PATIENT'S CARE

PATIENT: [REDACTED]  
DATE: 6/10/08

The patient was first seen for consultation on May 9, 2008. The patient was a [REDACTED]-year-old [REDACTED] who gave a history of morbid obesity and underwent over 110 lb weight loss through diet and exercise and the weight watcher's program. [REDACTED] explained [REDACTED] weight has been stable for the past six months and [REDACTED] complained of significant laxity of skin. At that time we discussed [REDACTED] past medical history as being significant for gastroesophageal reflux disease and history of epilepsy with [REDACTED] last seizure being in 1990. At that time [REDACTED] medications included Pravastatin 40 q. day for cholesterol, Biotin, vitamin B12 injections, Topamax 100 mg q. day, Lamictal 100 mg q. day for [REDACTED] seizure disorder and Armour Thyroid 45 micrograms q. day. [REDACTED] also took Prevacid b.i.d., calcium supplements, Allegra p.r.n., Tylenol and vitamins. At that time [REDACTED] gave a history of having allergies to Theophylline, Valium, Dilantin and Tegretol. [REDACTED] family history was positive for cancer, heart disease and high blood pressure. [REDACTED] review of systems were essentially negative. [REDACTED] was a single [REDACTED]-year-old [REDACTED] who retired from [REDACTED] job as a speech pathologist. [REDACTED] worked extensively overseas with the US Government. [REDACTED] denied drinking and smoking having quit smoking in 1989. At that time we recommended a medical evaluation to make sure there were no complicating medical conditions to preclude elective surgery. [REDACTED] was seen three days later on 5/12/08 by [REDACTED] physician, Bart E. Price, M.D. He performed a full history and physical examination with the following assessment of medical history of epilepsy, osteopenia, hypothyroidism, Barrett's esophagus, reflux disease, insomnia, increased cholesterol, lax skin due to weight loss and possible sleep apnea history resolved with weight loss. [REDACTED] was sent for blood work and EKG. CBC was normal. Urinalysis was negative. Blood chemistry level was normal. [REDACTED] showed sinus bradycardia with ventricular rate of [REDACTED] [REDACTED] Dr. Price [REDACTED] "sinus bradycardia with [REDACTED] P-wave progression but basically normal". [REDACTED] also had a pulmonary spirometry testing which according to Dr. Price was excellent with a FEV1 of 92% predicted. With this complete history and physical, blood work and EKG, we proceeded to prep the patient for mastopexy and brachioplasty. Originally the patient had considered having small silicone breast implants but on further consideration requested only mastopexy. On [REDACTED] history and physical evaluation performed in our office on 5/30/08, we confirmed the above medical history and medications as well as allergies. [REDACTED] review of systems was negative. [REDACTED] blood pressure was 156/80 with a pulse of 60 despite being normotensive on [REDACTED] physical examination performed by Dr. Price. This was attributed to some nervousness regarding the upcoming surgery. We recommended repeat evaluation of recent mammograms which had raised the question of a small soft tissue mass in the right breast. The patient went preoperatively to St. Pete General Hospital and obtained a mammogram and ultrasound which no longer showed any soft tissue density present. The patient had previous biopsy showing this to be a benign lesion. The patient came for surgery in the office OR on 6/5/08. [REDACTED] underwent a general orotracheal anesthesia performed by Dr. Ramsey Nashad of Palms of Pasadena Hospital. We performed bilateral brachioplasty and bilateral mastopexy. The surgery was uncomplicated and resulted in minimal blood loss due to the use of 500 cc of a tumescent local anesthetic

consisting of 500 cc of intravenous solution mixed with 30 cc ampule of 1% Xylocaine and a 1 cc ampule of 1:1000 epinephrine. Electrocautery was used and the patient had stable vital signs and tolerated the anesthesia well. [REDACTED] received 1,700 cc of lactated ringers during the surgery and put out approximately one liter of urine. No drains were required as there was excellent hemostasis. [REDACTED] was awakened, extubated and taken to the recovery room where despite some relative hypertension during the initial recovery period [REDACTED] was quite stable. [REDACTED] blood pressures were approximately in the 180 over mid 90's range and responded to 5 mg of Labetalol given twice followed by adequate control of [REDACTED] pain. This required two doses of Demerol intravenously but approximately two hours into [REDACTED] recovery room status [REDACTED] blood pressure had decreased to the 165/85 range. [REDACTED] heart rate was in the mid 60's and at approximately 11:30 in the evening [REDACTED] was transferred to the overnight stay area under the care of a registered nurse and a CNA. At this time [REDACTED] sequential compression boots were removed and TED hose were placed. [REDACTED] tolerated a liquid diet and [REDACTED] IV was removed. [REDACTED] was given 1 Percocet p.o. for pain approximately at 1:00 in the morning and had [REDACTED] Foley catheter removed after putting out 700 cc. [REDACTED] ambulated with assistance and at approximately 4:20 in the morning was given another single Percocet for pain but complained of pain one hour later and was given a second Percocet. I came to see the patient at 9:00 the morning following surgery and [REDACTED] was awake, alert and upright in the chair. Examination of [REDACTED] breasts revealed sealed incisions with no signs of hematoma or fluid collection. The dressings on the arms were intact without signs of bleeding and [REDACTED] pulses and capillary refill in the fingers were normal. [REDACTED] ambulated to the bathroom and was dressed and upright without signs of being unstable. [REDACTED] vital signs were as follows: Temp 98.4F, pulse 72, res 20, BP 150/76. [REDACTED] was then discharged home in the charge of [REDACTED] good friend, [REDACTED] who was given [REDACTED] postoperative care instructions as well as written instructions. I advised both the patient's caregiver and the patient that [REDACTED] should take one Percocet at a time approximately every four hours as-needed for pain. The patient was in good spirits and even joking about [REDACTED] desire to have abdominoplasty in the near future. Our office received a call some several hours later from the patient's caregiver, [REDACTED], stating that one Percocet did not seem to be handling the patient's pain and so our nurse advised that [REDACTED] prescription had been written for 1 to 2 Percocet's p.o. q. 4-6h. p.r.n for pain with a maximum dose of 8 per 24 hours. We last heard from [REDACTED] on the Friday following [REDACTED] surgery. This was June 6, 2008. We were notified mid morning the following Monday by the district 12 medical examiner's office that the patient died on the evening of June 6 approximately 24 hours after the finish of [REDACTED] surgery. I called the patient's friend, [REDACTED], to express my condolences. [REDACTED] explained that the patient had done well that afternoon following returning home from our office. [REDACTED] had been up and ambulating and drinking a considerable amount of water. They had been sitting on the sofa watching the evening news at approximately 7:00 p.m. when the decision was made that [REDACTED] should have some dinner. The patient got up to use the restroom, walked towards the bathroom and collapsed. [REDACTED] immediately called 911 and they were dispatched to the home expeditiously. They pronounced [REDACTED] dead. We were contacted by Abbey Andrus, investigator in the medical examiner's office, on 6/10/08 and I spoke with Ms. Andrus.

6/13/08

#199  
#67

# #199



STATE OF FLORIDA  
Jeb Bush, Governor

## PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:  
Department of Health, Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275

### I. OFFICE INFORMATION

Cardiology Consultants P.A.  
Name of office  
PENSACOLA 32504 Escambia  
City Zip Code County  
NANCY A. Riddlehoyer  
Name of Physician or Licensee Reporting  
NA  
Patient's address for Physician or Licensee Reporting

5151 North 9th Ave Suite 200  
Street Address  
850-857-1700  
Telephone  
License Number & office registration number, if applicable

### II. PATIENT INFORMATION

[Redacted]  
Patient Identification Number  
Increasing Chest Pain  
Diagnosis

[Redacted]  
Age 06-13-08 Gender \_\_\_\_\_ Medical/Medicare \_\_\_\_\_  
Date of Office Visit \_\_\_\_\_  
Purpose of Office Visit 958.0  
ICD-9 Code for description of incident  
NA  
Level of Surgery (II) or (III)

### III. INCIDENT INFORMATION

06-13-08  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Outpatient Cardiac Cath Lab.

Note: If the incident involved a death, was the medical examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No

A) Describe circumstances of the incident (narrative)  
(use additional sheets as necessary for complete response)

See Attached.

B) ICD-9-CM Codes

<u>93510-Left Heart Cath</u>	<u>958.0 Air Embolism</u>	<u>NONE</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident  
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcomes of transfer - e.g., death, brain damage, observation only <u>Observation Only</u> Name of facility to which patient was transferred <u>Sacred Heart Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
--	--

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Edwin W. Rogers, MD, M.B.A., F.A.C.C. - NE 38487, Cathing Physician, 5151 N 9th Ave, Suite 200  
Tracy Bokath, RN - license # 9113229, Nurse in Charge Also Recorder, 5151 N 9th Ave, Suite 200  
Vickie Sharp, R.C.I.S. - license # 316R331, CV Tech Sound on Case, 5151 N 9th Ave, Suite 200  
Brenda Davis, R.C.I.S. # 4D185, Circulating Tech, 5151 N 9th Ave, Suite 200

F) List witnesses, including license numbers if licensed, and locating information if not listed above

All Listed Above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

See Attached

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

See Attached

V. Nancy A. Hillman 73774-2  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
8-8-08 Ed. Rogers  
 DATE REPORT COMPLETED TIME REPORT COMPLETED