COPY 01/09/2001 .49

[redacted]

Chemo PY

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
00 DEC 28 AM 10: 53

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

Name of office: Florida Community Cancer Center

Street Address: 10441 Quality Dr - Suite 205

City: Spring Hill Zip Code: 34609 County: Hernando

Telephone: 352-688-7744

Name of Physician or Licensee Reporting: Dr. Peter Kennedy

License Number: ME0051561

Locating Information for Physician or Licensee Reporting:

II. PATIENT INFORMATION

Patien[redacted]

Locating Infor[redacted]

Patient Identification Number [redacted]

Diagnosis: Metastatic Lung Cancer

[redacted]

Age Gender ☐ Medicaid ☐ Medicare

Date of Office Visit: 12/11/00

Purpose of Office Visit: Chemotherapy

ICD-9 Code for Diagnosis: ~~20200~~ 1628

III. INCIDENT INFORMATION

Incident Date and Time: 12/11/00 10:30 AM

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☒ Other Chemo 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. recieved Taxol for 1st time, recieved premeds, IV started slowly, 5 minutes into infusion pt. started c/o chest pain. Taxol stopped immediately, Dr. Kennedy called into chemo room. Pt.'s face red + diaphoretic, c/o difficulty breathing and pain in lower back. Pt. given ativan .5 mg IVP + NS running wide open. Dr. Kennedy transported pt. next door to Spring Hill Regional Hospital via wheelchair.

B) ICD-9-CM Codes

V581	E933.0	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)

IV Pump, Wheelchair

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

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

Dr. Peter Kennedy MD - ME0051561
Margaret Dome RN OCN - RN 2512932
Dorothy Hollenstein - Lab Tech - TC 7674

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)

Adverse reaction to Taxol

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

Stopped infusion + transported pt. to Hospital for observation

V. Peter Kennedy MD ME0051561

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — LICENSE NUMBER

12/19/00 — 12:45 Pm

DATE REPORT COMPLETED — TIME REPORT COMPLETED

Form #

50

COPY 01/09/2001 [redacted]

Chemo M

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
00 DEC 28 AM 11:00

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

Florida Community Cancer & Imaging Center.
Name of office

11307 Cortez Blvd.
Street Address

Brooksville
City

34613
Zip Code

HERNANDO
County

352 596-1926
Telephone

Richard CARADONNA
Name of Physician or Licensee Reporting

ME0049404
License Number

11307 Cortez Blvd. Brooksville, FL.
Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

[redacted]
Age Gender

☐ Medicaid ☒ Medicare

[redacted]
Patient Identification Number

December 11, 2000
Date of Office Visit

Chemotherapy
Purpose of Office Visit

Colon Cancer
Diagnosis

154.0
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

December 11 2000
Incident Date and Time

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☒ Other Florida Community Cancer Center Chemo 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)

[redacted] had completed 5FU IV push + ½ of Leukovorin infusion. Approximately 10 minutes after 5FU, patient had a Grand Mal Seizure c̄ tremors, more pronounced on right side. Head turned to right - eyes deviated to right. Incontinent of urine - Snoring + tachypnea present. Airway protected O_2 per mask. 911 called. Initial BP 218/110. HR 120 - Resp 36. Subsequent BP 150/80. Ativan 0.25 IV push given. Seizure activity lasted approximately 8-10 minutes. Unable to grasp with right hand - Speech garbled. Transported to Oak Hill Hospital - E.R.

Form #

B) ICD-9-CM Codes

V58.1	E933.1	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)

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

Shirley White RN chemotherapy nurse
Linda White RN " "
Barbara Cara RN " "
Roberta Joseph RN " "

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

Roberta Joseph RN

IV. ANALYSIS AND CORRECTIVE ACTION

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

Patient Condition

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

None

[initials] 12-20-00

V. [signature] ME0049404
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT **LICENSE NUMBER**

12/18/00 2P.M.
DATE REPORT COMPLETED **TIME REPORT COMPLETED**

COPY 01/09/2001 51 [redacted]

nausea vomiting dehydration

RECEIVED
CONSUMER SERVICES UNIT
00 DEC 28 AM 11:59

CITRUS HEMATOLOGY AND ONCOLOGY CENTER
770 SE 5TH TERRACE
CRYSTAL RIVER, FLORIDA 34429 (CITRUS COUNTY)
TEL. 352-795-6674 FAX 352-795-2017

PHYSICIAN OFFICE INCIDENT REPORTING FORM

PATIENT'S NAME [redacted]

ADDRESS [redacted]

CITY/STATE/ZIP [redacted]

GENDER [redacted] DATE OF BIRTH [redacted] AGE [redacted]

☒MEDICARE ☐MEDICAID ☐OTHER ____ PATIENT ID# [redacted]

ICD9 CODE/DIAGNOSIS 150.5 Esophageal Ca. DATE OF VISIT 12-12-00

PURPOSE OF OFFICE VISIT Nausea/Vomiting

INCIDENT DATE AND TIME: 12/12/00 10:00 a.m.

LOCATION OF INCIDENT:
☐EXAM ROOM ☒CHEMOTHERAPY ADMIN ROOM ☐OTHER ____

IF THE INCIDENT INVOLVED A DEATH, WAS THE MEDICAL EXAMINER NOTIFIED?
☐YES ☒NO

WAS AN AUTOPSY PERFORMED? ☐YES ☒NO

DESCRIPTION OF INCIDENT (INCLUDE TIME, DATE, AND EXACT LOCATION WITHIN THE OFFICE)

Patient presented to office with nausea and vomiting. Admitted for fluids and anti-emetics.

ICD-9-CM CODES 536.2 Nausea/Vomiting 150.5 Esophageal Ca.	-	-
Surgical, diagnositc 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)

LIST ANY EQUIPMENT USED IF DIRECTLY INVOLVED IN THE INCIDENT: N/A

[redacted]

OUTCOME OF INCIDENT: ☐Death ☐Brain Damage ☐Spinal Damage

☐Surgical procedure performed on the wrong patient

☒Any condition that required the transfer of the patient to a licensed hospital.

☐Other

LIST ALL PERSONS DIRECTLY INVOLVED IN THE INCIDENT (INCLUDE LICENSE NUMBERS, LOCATION INFORMATION, AND A DESCRIPTION OF THE PERSON'S EXACT INVOLVEMENT AND ACTIONS)

Craig W. Englund, M.D. ME43357

Peggy Hinman, R.N. RN2173602

LIST ANY WITNESSES NOT IDENTIFIED ABOVE

Donna Stanton, R.N. RN3290602

ANALYSIS AND CORRECTIVE ACTION:
(Apparent cause) of this incident

Describe corrective or proactive action(s) taken: Admitted to Citrus Memorial Hospital for supportive care.

NAME OF PHYSICIAN Craig W. Englund, M.D. LICENSE NUMBER ME43357

ADDRESS 770 SE 5th Terrace

CITY/STATE/ZIP Crystal River, Florida 34429

SIGNATURE OF PHYSICIAN
(OR LICENSEE SUBMITTING THIS REPORT)

C.W. Englund, M.D.

DATE REPORT COMPLETED 12-22-00 TIME REPORT COMPLETED 10:50 a.m.

52

COPY 01/09/2001

Contrast Rx

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

Name of office: Advance Technological Radiology

Street Address: 500 US Highway 27N

City: DAVenport Zip Code: 33837 County: Polk

Telephone: (863) 421-8674

Name of Physician or Licensee Reporting: Anthony T. Rosa, M.D

License Number: ME 65596

Locating Information for Physician or Licensee Reporting:

II. PATIENT INFORMATION

[redacted]

Age [redacted] Gender [redacted] ☐ Medicaid ☒ Medicare

Date of Office Visit: 12/07/00

Patient Identification Number:

Purpose of Office Visit: CT Scan

Diagnosis: Liver Cyst, Gallstones

ICD-9 Code for Diagnosis: 789.07

III. INCIDENT INFORMATION

Incident Date and Time: 12/07/00 11:00 a.m

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☒ Other: out patient Radiology

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 SEE THE ATTACHED REPORT

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)
	UNKnown	None

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)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure
- X Any condition that required the transfer of the patient to a licensed hospital
- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure

** if it resulted in

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function;
- ☐ 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.

Techologist Mr Terry Bellman 37719
Mrs Terry Campbell 48876
Mrs Rhonda Nichols 45471
All can be reached at our office

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. Anthony T. [illegible] MD
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 65596
LICENSE NUMBER

12-22-06
DATE REPORT COMPLETED

1145 Am
TIME REPORT COMPLETED

TOTAL P.03

ADVANCE TECHNOLOGICAL RADIOLOGY, P.A.

A.T. RADIOLOGY, P.A.

❑ 315 Central Ave. East
Winter Haven, FL 33880-3012
Phone: (863) 295-5674
Fax: (863) 295-5719

❑ 500 U.S. Hwy. 27 North
Davenport, FL 33837
Phone: (863) 421-8674
Fax: (863) 421-2615

PATIENT NAME: [redacted]
DATE OF STUDY: 12/07/2000
JACKET #: [redacted]
PHYSICIAN: Dr. Jacobo N. Lama

EXAMINATION PERFORMED: CAT scan of the abdomen with and without contrast.

INTERPRETATION:
Compared with an ultrasound dated 07/31/2000.

A 4 cm cyst like structure is identified centrally in the anterior segment of the right hepatic lobe. There are a few small satellite cyst like structures noted. No enhancing masses are shown. No suspicious hepatic lesions are evident. The spleen, pancreas and adrenal glands and kidneys appear unremarkable. No abdominal lymph nodes are evident. There appears to be a large calculus within the gallbladder.

Ultrasound from 07/31/2000 demonstrates an echogenic structure immediately adjacent to the hepatic cyst. This was not appreciated on the CAT scan.

Limited scans through the lung bases reveal no pulmonary nodules.

After the CAT scan with contrast was completed and the patient was fully dressed and had left the dressing room area, [redacted] reportedly did not feel well and had a syncopal or near syncopal episode. The technologist immediately notified me. At my arrival, the patient was lying down in the tech area. Blood pressure at that time was 180/120, pulse rate 96, respirations approximately 20. The patient stated that [redacted] did not feel well. There was no chest pain, shortness of breath or wheezing noted. The heart had a regular rhythm. The patient was provided nasal cannula oxygen and hydrated with normal saline intravenously. Emergency medical services was contacted as, after approximately five minutes, the patient continued not to feel well. No urticarial skin reactions were identified. The patient did not complain of headaches. There was some shivering but we thought that this was due to the patient lying on the floor. We placed a blanket over the patient and provided reassurance.

A.T. RADIOLOGY, P.A.

315 Central Ave. East
Winter Haven, FL 33880-3012
Phone: (863) 295-5674
Fax: (863) 295-5719

500 U.S. Hwy. 27 North
Davenport, FL 33837
Phone: (863) 421-8674
Fax: (863) 421-2615

[redacted]
CAT scan of the abdomen with and without contrast
Page 2

IMPRESSION:

1. Simple appearing cyst with smaller satellite cyst like structures in the central aspect of the anterior right hepatic lobe. The small echogenic lesions shown adjacent to the cyst on the ultrasound from 07/31/2000 is not appreciated on this CAT scan. Therefore, we would recommend a follow up ultrasound as this was the imaging modality that made the echogenic lesion.
2. Large gallstone.
3. The patient became hypertensive with general sense of not feeling well and had a syncopal or near syncopal episode. The patient was ultimately transported to the Heart of Florida Hospital by EMS services.
4. It is in my opinion that the patient should probably not receive intravenous contrast unless properly pre-medicated.

ATM

Anthony T. Rosa, M.D.

ATR/mlt
D: 12/08/2000
T: 12/08/2000

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STATE OF FLORIDA
Jeb Bush, Governor

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00 DEC 22 AM 11:07

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

Name of office: Florida Community Cancer Center

Street Address: 10441 Quality Dr Suite 205

City: Spring Hill Zip Code: 34609 County: Hernando

Telephone: 352-688-7744

Name of Physician or Licensee Reporting: Dr. Peter Kennedy

License Number: ME 0051561

Locating Information for Physician or Licensee Reporting:

II. PATIENT INFORMATION

[redacted]

Patient [redacted]

Loca[redacted]

Patient Identification Number

Age [redacted] Gender

☐ Medicaid ☒ Medicare

Date of Office Visit: 12/7/00

Purpose of Office Visit: Chemotherapy

Diagnosis: Lymphoma

ICD-9 Code for Diagnosis: 20200

III. INCIDENT INFORMATION

Incident Date and Time: 12/7/00 12:30pm

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☒ Other Chemo Rm

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 recieving test dose of Rituxan. After approximately 90% of test dose infused, pt. complained of chills c̄ shaking. Rituxan immediately stopped, NS remained infusing. Over next couple minutes pt. became pale, diaphoretic + nauseous, Dr. Kennedy called into chemo room. Pt. then vomited + became unresponsive. 911 called. Dr. Kennedy + myself cared for pt. till paramedics arrived and transported patient to Spring Hill Regional Hospital.

B) ICD-9-CM Codes

V581	E933.0	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)

IV Pump + O2

D) Outcome of Incident (Please check)

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

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

Dr. Peter Kennedy MD - ME0051561
Margaret Dome RN OCN - RN 2512932
Dorothy Hollenstein Lab Teck - TC 7674

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)

Adverse Reaction to Rituxan

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

Stopped infusion + transported pt. to Hospital for observation

V. Margaret Dome RN OCN — RN2512932

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — LICENSE NUMBER

12/15/00 — 3:00 PM

DATE REPORT COMPLETED — TIME REPORT COMPLETED

Form #

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COPY 01/09/2001

IVIG reaction

[redacted]

STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
01 JAN -5 PM 12: 34

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

I. OFFICE INFORMATION

Name of office: Sun City
City: Sun City Zip Code: 33573. County: Hillsborough
Name of Physician or Licensee Reporting: Ahad.
Locating Information for Physician or Licensee Reporting: FLORIDA COMMUNITY CANCER CENTERS
Street Address: 4031 Upper Creek Dr
Telephone: 813-633-2733.
License Number: ME 77951

II. PATIENT INFORMATION

Patient Name: [redacted]
Locating Information: [redacted]
Patient Identification Number: [redacted]
Diagnosis: Lymphoma
Age: [redacted] Gender:
☐ Medicaid ☐ Medicare
Date of Office Visit: 12/20/00.
Purpose of Office Visit: IVIG Infusion
ICD-9 Code for Diagnosis: 202.80

III. INCIDENT INFORMATION

Incident Date and Time: 12/20/00 9:00 AM.

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)

Pt IV' started and pre-meds given. 5 mins into IVIG Infusion
pt c/o chest tightness, throat swelling and malaise.
IVIG Stopped, Normal Saline wide open, DR Ahad
brought into chemo room for Assessment. Decadron 10mg
given IVP, Pt remained stable but uneasy c̄ symptoms
Epi 1mg given IVP, Pt continued to have chest tightness,
emesis and defecated. 911 called, Supported pt
until transport to hospital. Pt remained conscious
during episode.