

2000



STATE OF FLORIDA
Jeb Bush, Governor



PHYSICIAN OFFICE VISIT SERVICES UNIT
ADVERSE INCIDENT REPORT

01 JUL -2 0111:57

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: Brooksville Fla. Comm Cancer Center
City: Brooksville FL Zip Code: 34613 Community: Hernando
Name of Physician or Licensee Reporting: De La Padrona MD
Location of Office: Brooksville FCCC

Street Address: 11367 Cortez Blvd
Telephone: 352 596 1926
License Number: ME E 0049404

II. PATIENT INFORMATION

Patient Identification Number: [Redacted]
Diagnosis: Lymphomas, neuroendocrine carcinoma & liver mets

Age: 6-18-0 Gender: [Redacted] Medical Record # [Redacted]
Date of Office Visit: 6/22/01
Purpose of Office Visit: check up treatment
ICD-9 Code for Diagnosis: 202.80

III. INCIDENT INFORMATION

Incident Date and Time: 6-18-01 Brooksville FCCC 12:35pm

Location of Incident:
 Operating Rm Recovery Rm
 Other: Waiting List

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

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)
after chem treatment client left building [Redacted] several minutes later [Redacted] came in + said [Redacted] in truck very short of breathe + nausea. RN went to assess client breathing very fast, skin pink, no pulse. Called for 911 (EMS) + another RN to assist. Client continued to have dyspnea, gradual dusky red to top of ears. On placed on O₂ 4P via nasal cannula, EMS arrived very quickly + transported to ER where a silent MI was diagnosed. Client admitted to hospital.

3) ICD-9-CM Codes

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

158.0

silent MI 410.9
dyspnea 300.0
Accident (event) circumstances, or specific agent that caused the injury or event. (ICD-9E-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"/> 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 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 that includes 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.

W 60150-2 BARBARA Ann RIVICH - 1st RN to answer when dyspnea occurred
RN 1838022 Terry Morgan RIVICH - 2nd RN to answer Mary Ann the result on secretary who got her all at F&B - Brownville except [redacted] who is best patient

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)

Client had a silent MI & leaving treatment area which caused severe dyspnea.

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

Oz put on nurse assess sent to ER via EMT

V. SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

BRK028043
LICENSE NUMBER

6-30-01
DATE REPORT COMPLETED

3:00 P.M.
TIME REPORT COMPLETED

MW
1-25-01

11/01/01



STATE OF FLORIDA
Jeb Bush, Governor



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

CONSUMER SERVICES UNIT

01 JUL -2 AM 11:57

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 CTR
Name of Office

3501 MEDICAL CENTER AVE.
Street Address

SEAFORD HILLS 33540 PASCO
City Zip Code County

813-783-1676
Telephone

LARRY CANALE
Name of Physician or Licensee Reporting

ME 51803
License Number

Elizabeth Kutsch LPN
Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 6-25-01 Gender _____ Medical _____ Medicare _____

Patient Identification Number

Date of Office Visit

Non-small cell Lung Carcinoma Stage III
Diagnosis

Begin Radiation treatments
Purpose of Office Visit

162.3
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

6-25-01 10:30am
Incident Date and Time

Location of Incident:
 Operating Rm. Recovery Rm.
 Other Office Lobby

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)

 came to the office today to begin Radiation Tx's to the Lung area. While waiting, began to feel faint, began to perspire, skin was cold, and became pale. Patient was taken into the exam room, where began to vomit. Vital signs were taken, BP 160/88 P 92 R 24. Dr Hughes was called who is the patient's PCP his orders were to call 911 and have patient go to the EPMC Emergency Room. This was done and EMT took patient via stretcher to the Emergency Room. followed patient in car. Dr Gandle, Dr Bishay were notified, Dr Kawauchi, chemotherapy phy. was also notified.

B) ICD-9-CM Codes

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

Syncope 782
Accident, event, circumstances, or specific agent that caused the injury or event.
(ICD-9 E-Codes)

Unknown
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)

Blood pressure tool

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.

Elizabeth Kutsch LPN PN 370501

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

Rosemary Libby

IV. ANALYSIS AND CORRECTIVE ACTION

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

Syncope/ Dehydration/ Low Blood Counts

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

Patient was taken to East Pass Medical Ctr. Emergency Room via stretcher and EMP's assist

V.

[Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 51803
LICENSE NUMBER

6/25/01
DATE REPORT COMPLETED

11:30 AM
TIME REPORT COMPLETED

MW 6-26-01



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT (JUN 03 2001)

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

I. OFFICE INFORMATION

Name of office: Edward H. Farris, M.D., F.A.C.S.

City: Tampa Zip Code: 33609 County: _____

Name of Physician or Licensee Reporting: Barbara Dame, LHCRM

Location Information for Physician or Licensee Reporting: 3853 Serubi Ave., Lakewood, FL 33461

Street Address: 2908 Azeele Street

Telephone: 813-875-3223

License Number: 5500888

II. PATIENT INFORMATION

Name: [REDACTED]

Last Name: [REDACTED]

Patient Identification Number: _____

Diagnosis: Brow ptosis - Dermatochalasis
Blepharochalasis

[REDACTED]

Age: 6-19-01 Gender: _____ Medicaid/Medicare: _____

Date of Office Visit: Facial Plastic Surgery

Purpose of Office Visit: 701.8 - 701.8 - 374.87

ICD-9 Code for Diagnosis: _____

III. INCIDENT INFORMATION

Incident Date and Time: 6/19/01

Location of Incident: Operating Rm Recovery Rm Other _____

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)

End of surgery the patient was extubated, immediately patient's breathing became labored and Sa O2 decreased to 89-90%. Within one minute of extubation assisted ventilation was not adequate to maintain Sa O2, patient reintubated and Ambu bagged with 100% oxygen. Sa O2 returns to normal. Vital signs stable. Suctioned for pink tinged secretions R/o pulmedema/CHF. Patient responded to painful stimuli but would not wake up. Paramedics called, patient transferred to Memorial Hospital and admitted to unit.

01 JUN 19 PM 4:02
CONSUMER SERVICES UNIT

9) ICD-9-CM Codes

08.70 - 86.82
Surgical, diagnostic, or treatment procedure being performed at time of incident
(ICD-9 Codes 01-99.9)

876.9
Accident, event, circumstances, or specific agent that caused the injury or event.
(ICD-9 E-Codes)

N/A - No Injury
Resulting injury
(ICD-9 Codes 800-999.9)

G) 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 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.

Edward Farrior, M.D. - ME 0050318 - Surgeon

Debra Herr, CRNA - ARNP 270-2392 - CRNA

Maxie Coven, CST - CST 4070 - Surgical Tech

Leigh Atkins, LPN - PN 0848441 - Circulator

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)

Patient was extubated the following morning 6/20/01 and discharged the next morning 6/21/01. It was identified that the patient had sleep apnea not diagnosed prior to date of surgery. [redacted] is under the care of pulmonologist.

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

This event could not have been prevented. As diagnosis of sleep apnea never discovered until surgical event. All staff responded appropriately and participated in the event, as per facility protocol.

V. [Signature] 5500888
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
6/29/01 4pm
DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA
Jeff Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

CONSUMER SERVICES UNIT

01 JUL -9 AM 11:54

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

I. OFFICE INFORMATION

FL Comp CANCER Ctr
Name of Office
13807 Cantel Blvd
City Zip Code County
D. CARADONNA
Name of Physician or Licensee Reporting

11307 Cantel Blvd
Street Address
352-596-1926
Telephone
ME 49404
License Number

Localing Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

██████████
Patient Name
██████████
Localing Information
██████████
Patient Identification Number
██████████
Diagnosis

██████████
Age 61 5/12 Gender Male Female
Medicaid/Medicare
Date of Office Visit
Chemo Treatment
Purpose of Office Visit
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

6/25/01
Incident Date and Time

Location of Incident
 Operating Room Recovery Room
 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)

PATIENT RECEIVED TAXOL for first time, AFTER RECEIVING PRE-MEDS. PT WAS STARTED ON TAXOL 6mg
VER, slowly, SOME AN HOUR. TAXOL CONT WAS MIXED IN A 250ml bag of NS. TRANSDIPH
15 minutes WAS INCREASED TO 100cc/hr, PT STARTED TO EXPERIENCE SEVERE SOB, FACE HAD TURNED RED.
PT HAD BEEN ON 1/4 O2 AT 2:30, PT WAS GIVEN SOLIMEDIN + BRIDILIX, 911 WAS CALLED. PT
DIP HAD INCREASED TO 100% P.O2, PT STILL SOB, FACE TURNED DEEP RED, EMTs ARRIVED
PT PLACED ON STRECHER AND PT TRANSPORTED TO OAK HILL HOSPITAL, PT STILL SOB ON 1/4 O2, PT'S
FACED PINK LEUCED, PT TAKEN TO O.H.H.; PT OBSERVED 24 HOURS
AT HOSPITAL HOSPITAL AND RELEASED IN GOOD
CONDITION.

B) ICD-9-CM Codes

V58.9

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-9E-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)

D) Outcome of incident (Please check)

<input type="checkbox"/> Death	<input checked="" 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 a 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.

John C. Bredtmer RN 2729692
Robert Joseph RN 275848L

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 had Allergic Reaction to Taxol

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

911 CALLED - pt transfer to OAK HLT Hospital

v. X Robert R. Carlsom ME 4944
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

6/28/01
DATE REPORT COMPLETED

TIME REPORT COMPLETED



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT

01 JUL -9 03:11:56

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

I. OFFICE INFORMATION

FL COMA CANCER CTR
Name of Office
Bradonias FL 34613
City Zip Code County
D. Casadomar
Name of Physician or Licensee Reporting

11307 Carter Blvd
Street Address
352-596-1926
Telephone
ME 49404
License Number

Locating information for Physician License Reporting

II. PATIENT INFORMATION

[Redacted]
Patient Name
[Redacted]
Locating Information
[Redacted]
Patient Identification Number
[Redacted]
Diagnosis
[Redacted]

[Redacted]
Age 6/25/01 Gender [Redacted] Medical/Medicare
Date of Office Visit
Chemotherapy
Purpose of Office Visit
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

6/25/01
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other Chem 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 if necessary for complete response)
PATIENT RECEIVED TAXOL FOR FIRST TIME AFTER RECEIVING PRE MEDS. PT WAS STARTED ON TAXOL 6mg/kg
VER. SLOWLY 50mg AND DROPPED. TAXOL 6mg/kg WAS ADMINISTERED IN A 250ml BOTTLE OF NS. TAXOL PT
WAS INCREASED TO 100mg. PT STARTED TO EXPERIENCE SEVERE SOB, FACE HAD TURNED RED.
PT HAD BEEN ON 1/2 O2 AT 2L. PT WAS GIVEN SOLU MED 4mg AND 911 WAS CALLED. PT
O2 HAD INCREASED TO 10LPM. PT STILL SOB, FACE TURNED LEGN RED. EMTs ARRIVED
PT PLACED ON STRETCHER AND PT TRANSPORTED TO OAK HILL HOSPITAL. PT STILL SOB ON 1/2 O2. PT'S
FACED PINK. LEGS RED. PT TAKEN TO O.H.H.; PT OBSERVED 24 HOURS
AT HOSPITAL HOSPITAL AND RELEASED IN GOOD
CONDITION.

15 minutes



MEMO

STATE OF FLORIDA
Jeb Bush, Governor



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

CONSUMER SERVICES UNIT
01/30/10 11:30

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: Space Coast Medical Associates
City: Titusville Zip Code: 32784 County: Brevard
Name of Physician or Licensee Reporting: Dr. Richard Levine
Localing Information, for Physician or Licensee Reporting: 850 Century

Street Address: 850 Century Medical Drive
Telephone: 321-268-4200
License Number: 40927

II. PATIENT INFORMATION

[Redacted Patient Information]
Patient Identification Number: OVATION CA
Diagnosis: _____

Age: 73/01 Gender: _____
 Medicaid Medicare
Date of Office Visit: Chemotherapy
Purpose of Office Visit: _____
ICD-9 Code for Diagnosis: _____

III. INCIDENT INFORMATION

Incident Date and Time: 7/3/01 1120

Location of Incident:
 Operating Room Recovery Room
 Other: Clinic 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 receiving Chemotherapy up to bathroom, clo not being able to breathe, patient b/p 90/68 p90 irregular
Dr Levine in office assessed patient, 911 called.
Patient taken to hospital.

B) ICD-9-CM Codes

chemotherapy infusion
Surgical, diagnostic, or treatment procedure being performed at time of incident 96.412
(ICD-9 Codes 01-99.9)

(chemotherapy)

Reaction to Toxic or anaphylaxis
Accident, event, circumstances, or specific agent that caused the injury or event. J9045, J9040
(ICD-9 E-Code)

sketches of Death
786.09
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)

iv. Ca chemotherapy infusion

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.

RICHARD L. GIVENS MD Managing physician
MARION HANDEL RN oncology nurse
LINDA MATTHEW RN oncology nurse

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

N/A

IV. ANALYSIS AND CORRECTIVE ACTION

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

ADVERSE REACTION TO CHEMOTHERAPY TREATMENT FOR PATIENTS CANCER.

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

Patient treated with Benadryl, Lorazepam
chemotherapy stopped. All cancer patient
transferred to hospital ER

V. [Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
7/3/81
DATE REPORT COMPLETED

40927
LICENSE NUMBER

6:20 pm
TIME REPORT COMPLETED



STATE OF FLORIDA
Jon Bush, Governor

108
MEDICAL SERVICES UNIT
01 JUL 81 01 05:37

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: Cancer Centers of FL
City: Orlando Springs Zip Code: 32701 County: Seminole

Street Address: 505 N. Mainland Ave
Telephone: (407) 339-6974

Name of Physician or Licensee Reporting: _____

License Number: _____

Loading Information for Physician or Licensee Reporting: _____

II. PATIENT INFORMATION

Age: _____ Sex: _____
Race: _____
Patient Identification Number: _____
Diagnosis: Cela can, liver mets

Age: 41/8/01 Gender: _____
Date of Office Visit: 06/18/01
Purpose of Office Visit: chemotherapy
ICD-9 Code for Diagnosis: 153.3 V56.1

III. INCIDENT INFORMATION

Incident Date and Time: 4/15/01 11:30A

Location of Incident:
 Operating Rm Recovery Rm
 Other, located in Chem room
pt moved to patient 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 responses)

pt in for Chemotherapy. C/o nausea & neutrocin started. Zofran 80mg
given to pt, then a 10-15 min pt states nausea better, but having
low back pain and unable to get comfortable. Pt stated [redacted] felt like
[redacted] was having palpitations and asked to have BP checked; BP 127/92
pt also stated to be claustrophobic. States [redacted] might feel
better if [redacted] could lie down straight. Pt assisted to exam room
to lie on exam table. Pt still unable to get comfortable, and
continued to change positions & relief. [redacted] stated stated that the
pain was severe but didn't bring [redacted] pain medication (at has her

cartridge in [redacted] back). About halfway through neutrocin infusion pt
started having chills & C/o SOB & labored breathing. Dr. Simon notified.
1 of 2 pages Pt asked to have 176 mg, Dr. Simon in to assess pt. O2 @ 2 L/min
was placed on Pt. Neutrocin stopped & NSS started. Pt did not feel
any ill after called to transport pt to ER for further evaluation
per Dr. Simon order & [redacted]

Capt. Jackson (Lark)

States [redacted] wants to see what the [redacted] will do with
[redacted] first, since [redacted] doesn't drive and [redacted] would
have to find someone to bring [redacted] to the hospital.

D. [redacted]

B) ICD-9-CM Codes

V58.1

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)

Unknown
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)

None

D) Outcome of Incident (Please check)

<input checked="" type="checkbox"/> Death the next day	<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 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.

Donya [Signature] - Nursing

[Signature] 2624222

Dr. Kenneth Simon 05669158 - embedded at

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

See above

IV. ANALYSIS AND CORRECTIVE ACTION

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

UNKNOWN (See separate incident A #1)

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

Called 911, pt transferred to hospital.

V. [Signature] 2624222
 SIGNATURE OF PHYSICIAN LICENSE SUBMITTING REPORT LICENSE NUMBER
 571401
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

CONSUMER SERVICES UNIT
21 AUG -7 10:11:28

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
Kelly Botes LPN
Name of Physician or Licensee Reporting
Same as above
Locating Information for Physician or Licensee Reporting

7600 Lakeland Hills Blvd
Street Address
863-680-7000
Telephone
PN 1289541
License Number

II. PATIENT INFORMATION

[Redacted]
Patient Name
[Redacted]
Patient Identification Number
AV Block
Diagnosis

[Redacted]
Age 8-1-01 Gender Male Insurance Medicaid
Date of Office Visit
Pacemaker threshold check
Purpose of Office Visit
426.0
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

8-1-01 Approx. 2p
Incident Date and Time

Location of Incident
 Operating Rm Recovery Rm
 Other Pacer 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)

Pt. was in office for a pacemaker threshold check and after threshold check pt. was reprogrammed and became very symptomatic and passed out briefly. Stat pacing was initiated. Dr. applied, blue team called, Dr. Simuk assisted, cardiologist called, 911 called, IV started and pt. was transported to LMMC via EMS per Dr. Bongaly to m3. Pain to transporting to LMMC pt. was stable, alert and oriented. Dr. Bongaly to notify LMMC.

B) ICD-9-CM Codes

93735
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

93735
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

427.5
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)

pacient zoom programmer

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

Sally Support LPN PN120431 Applied on face of patient
Patricia Powell LPN PN452571 Stat Pace Victoria Vowell
Kelly Bales LPN PN1289541 Threshold dome Kelly Bales
Lynn Cowans LPN PN1088731 ISO taken, threshold
Christopher Simek MD 0062055

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 reprogrammed after threshold, became symptomatic at new settings. Stat Pace at high settings, reprogram to previous settings

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

Patient was treated for symptoms by Atopy and Cardiologist.

V. Kelly Bales PN 1289541
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
8-2-01 4:50 AM
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

CONSUMER SERVICES UNIT
01 AUG -7 2011:25

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
JEREMY R. GEFREN MD & ASSOCIATES PA

981-37th PLACE

Street Address

CITY VERO BEACH ZIP CODE 32960 COUNTY INDIAN RIVER

561-770-5800

Telephone

NAME OF PHYSICIAN OR LICENSEE REPORTING
JEREMY R. GEFREN, MD

ME 0051697

License Number

Locating information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

Patient Identification Number:
STAGE IV NON-SMALL-CELL LUNG COCAINE USE

Age 8-01-01 Gender Male Medical History
Date of Office Visit
Purpose of Office Visit CHEMOTHERAPY
ICD-9 Code for Diagnosis 162.5

III. INCIDENT INFORMATION

INCIDENT DATE AND TIME
August 1, 2001 9:45 AM

Location of Incident:
 Operating Rm Recovery Rm
 Other Cotton Cause Center - Chem 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)

9:45 AM patient presented for Chemotherapy. [Redacted] was administered at 9:45 AM with
lymph node after ascending to upper part without difficulty & hanging a
ASOC as primary line use. At 9:50 AM received another 50mg & duration in
AVCB was 15min. At 9:55 AM patient felt chest tightness & shortness of breath. SpO2
went down to 86. Vital signs were 88, 120/80, 102, 20. Patient was given
nasal cannula 2L/min. Patient was placed in supine position. After
5 min. patient remained with chest pain #6 & 7. At 10:10 increasing
to #8 with irregularity. At 10:15 patient made awake & 9:11 activated
for transport to Indian River Memorial Hospital. At 10:20

B) ICD-9-CM Codes

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

Chemology unknown
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"/> 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.

MAUREN VAN NIMME R.N. RN 1875752
JEANNINE SMITH R.N. RN 2199512 } CHEMO THERAPY
JUNE GOODRICH R.N. RN 2582462 } NURSES IN ROOM
primary case givers.

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)

Chemology of chemo given was incorrect.

NOTE: PT seen in ER AT I.R.M. HOSPITAL - CXR; LABS; EKG; ENZYMS ALL NEGATIVE.

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

activated Emergency medical Service (EMS) for transport. The emergency room at Jackson Memorial Hospital.

J.R. Jefferson ME 0051699
SIGNATURE OF PHYSICIAN LICENSEE SUBMITTING REPORT LICENSE NUMBER

8-1-01
DATE REPORT COMPLETED

3:00 pm
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 14080,
Tallahassee, Florida 32317-4000

I. OFFICE INFORMATION

Name of office: Physicians Institute of Cosmetic & Reconstructive Surgery
Address: 3449 Johnson Street
City: Hollywood Zip Code: 33021 County: Broward
Telephone: 954-964-4113
Name of Physician or Licensee Reporting: Jeffrey C. Necker M.D.
License Number: ME 00604761

Location Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

Age: 8/3/01 Gender: Male Medicaid/Medicare: Medicaid Medicare
Date of Office Visit: Surgery
Purpose of Office Visit: Surgery
ICD-9 Code for Diagnosis: _____

III. INCIDENT INFORMATION

Incident Date and Time: 8/2/01 11:30 AM
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. tolerated elective surgical procedure (ORBimax Full Face lift, upper & lower lid Blepharoplasty, + cervicoplasty) without incident. However, went into Respiratory Failure after extubation, so he went to Pulmonary and Critical Care Intensive Care and transfer to Memorial Regional Hospital for ventilatory support and intubation.

RECEIVED
AUG 15 2001
11:24 AM

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-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"/> 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 checked="" 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.

	License #
Terrance J. Uscella D.O. (Anesthesiologist)	05-0005848
Jethro C. Uecker M.D. (Surgeon)	ME 0064761
ANN G. Siler (A.N.) (Circulator)	1023102
Holly Schweizer (A.N.) Scrub	2850262

F) List witnesses, including license numbers if licensed, 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)

Apparently episode was caused by Pt's O2 and medical conditions (cardiac disease and hypertension) and may have suffered an acute myocardial infarction.

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

Appropriate care was given to this Pt and in a timely fashion.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 0064761
LICENSE NUMBER

8/7/01
DATE REPORT COMPLETED

9:15 AM
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

6-0011
Michael A Scott MD / Associates PLC

I. OFFICE INFORMATION

Name of office Michael Scott MD

City Vero Beach Zip Code 32960 County Indian River

Name of Physician or Licensee Reporting Frederick M Weeks MD

Locating Information for Physician or Licensee Reporting see last

Street Address 1460 36th Street

Telephone 561-562-7777

License Number ME 0003716

II. PATIENT INFORMATION

Locating Information [Redacted]

Age 71 Gender Male Medicaid Medicare None

Date of Office Visit 07/30/01

Patient Identification Number [Redacted]

Purpose of Office Visit Appt rechemo

Diagnosis 153 1123

ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

Incident Date and Time 07/30/01 - 11:15 AM

Location of Incident: Operating Rm Recovery Rm Other Chemotherapy 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) See attached
(use additional sheets as necessary for complete response)

11:5 Pt given morphine IV for the first time today since we've been in since. Pt tolerant
with this time. 15mg morphine IV. Pt started feeling
lightheaded. 3/4 15mg P.O. Ativan long TUP given. Dr Weeks not found to see Pt.
Pt's of feeling distressed - over next few minutes Pt got slight SOB. Dr Weeks
reassessed Pt who was now developing rales - for Navelbine insert
this respiratory problem was rare. As per insert and Dr Weeks a 200% diluent TIV
given and 911/paramedics called - O2 @ 3L was also placed on Pt at
approx 11:50 - / approx 12:05 Pt sent via ambulance to TRUW ER w instructions
per Dr Weeks to paramedics to deliver 40mg Lasix IV -

B) ICD-9-CM Codes

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

Pt allergic reaction to Navelbine / Respiratory problems
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)
Chemotherapy Drug: Navelbine 55mg / Demerol 10mg, 3-02

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.

- Mildred Auer RW - Nurse in charge of Chem. room @ time of incident and nurse who administered meds - License # 2687182
- Misty Sanders RN - Nurse helping in Chem. room (License #) 1069501
- Patrick Weeks MD - Pts doctor and doctor who managed pt until transport. License # ME 63714

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

Above named persons

IV. ANALYSIS AND CORRECTIVE ACTION

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

Pt appeared to have adverse reaction to New (iv) med [redacted] had just started today - Navelbine -

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

Pt will not get this medication (Navelbine) again - due to adverse reaction [redacted] had -

v. [Signature] [Signature] 1069501 - ME 63714
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
08/01/01 1530
 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

Florida Allergy
Name of office
Tampa Hillsb.
City Zip Code County
Annis K. Ledford, M.D.
Name of Physician or Licensee Reporting

13801 Bruce Downs Blvd
Street Address # 502
813/991-9943 x109
Telephone
305111
License Number

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient Name
[Redacted]
Locating Information
[Redacted]
Patient ID
[Redacted]
Diagnosis

[Redacted] Medicare Medicaid Medicare
Age 8/16/01
Date of Office Visit
Purpose of Office Visit immunotherapy
ICD-9 Code for Diagnosis 95117

III. INCIDENT INFORMATION

3/16/01
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)

Allergy was used administered in
my office. [Redacted] removed
300 mins after injections. Patient
complained of throat, larynx, mild
headache. Patient left office but 1
hour later returned to Home Center
(Dunwoody, Tampa w/ symptoms
of chest tightness, swollen
throat and nasal. [Redacted]
re-evaluated.

B) ICD-9-CM Codes

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)
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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 licensed hospital N/A - Complete Recovery	<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.

Resident (Lester) Dept. Office / *Michelle Thompson, MD*
MD - medical assistant

F) List witnesses, including license numbers if licensed, 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)

DELAYED REACTION ROOM FOLLOWING ALLERGEN
ADMINISTRATION

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

NONE INDICATED WILL CONTINUE STANDARDS OF CARE
FOR ALLERGY ADMINISTRATION WHICH INCLUDES

ADMINISTRATION IN THE PRESENCE OF PHYSICIAN WITH
50 MIN OBSERVATION BEFORE LEAVE

V.
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT: *[Signature]* LICENSE NUMBER: *ME0034340*
 DATE REPORT COMPLETED: *8/23/01* TIME REPORT COMPLETED: *PATIENT LEAVE*

Date: 8/28/01 Provider: FREDDIE MCRAE MD Note ID: 1472646 PNOTE

ST. PETERSBURG-SUNCOAST MEDICAL GROUP
Phone: (727) 894-1818

08-28-01

PROGRESS REPORT

PHYSICIAN: FREDDIE L. MCRAE, M.D.

had a fibroadenoma of the left breast excised on 07/26/01. She was seen in the office on 08/10/01 and had had some bleeding that had stopped. There was some slight ecchymosis and induration in the area. She was started on Keflex and warm soaks and scheduled to come back in four weeks.

She completed the Keflex along with the warm soaks. She then noticed there appeared to be a little gauze coming through the incision and a foul odor. She called, we scheduled her to come in right away.

On checking today in the office indeed there is some white fibers. The area is opened up and there was a gauze sponge that was removed. We then irrigated the area with saline and flushed it with 1/4% Mercaine.

She will be restarted on Keflex 500 q.i.d. and rechecked again in three days.


Freddie L. McRae, M.D.
ID: 08/28/01 T: 8/28/01 Job: 13865/13870

F.L.M./268
002



DATE OF OPERATION:
OPERATING PHYSICIAN:

07/26/2001
FREDDIE L. MCRAE, M.D.

OPERATION(S):

Needle localization and outer
quadrantectomy, left breast.

PREOPERATIVE DIAGNOSIS:

Left breast mass.

POSTOPERATIVE DIAGNOSIS:

Fibroadenoma, left breast.

ANESTHESIA: Monitored anesthesia with controlled sedation
by Dr. Tortorice and nurse, English C.R.N.A.

PATHOLOGY SPECIMEN: Yes.

FINDINGS: The patient had approximately 1.5 cm oval
fibroadenoma after a operating room consultation with Dr.
Mumphrey.

PROCEDURE: The patient has had prior needle
localization. She then came to the operating room. The area
was prepped and draped. Next, Xylocaine and Marcaine was
infiltrated and an elliptical incision outlined. We made a
transverse incision, elevated the skin flaps to the ellipse,
and took the core breast tissue, down pass the needle. We
sent this for x-ray, which confirmed we did have the mass.
Hemostasis obtained with cautery. Wound closed in 2 layers
with interrupted 3-0 Vicryl deep and 4-0 Monocryl on the
skin. Mild pressure dressing applied. The patient tolerated
the procedure well and went to holding in stable condition.

Freddie L. McRae, M.D.

CBay Systems, Ltd., 51671, 07/26/2001, 07/26/2001 20:58:25,
8091957

cc: RICHARD OLDENSKI, M.D.

PATIENT NAME: GRIFFIS, KRISTEN
MR#: 545839

PHYSICIAN NAME: FREDDIE L. MCRAE, M.D.
BILLING #: 12297322
OPERATIVE NOTE

ROOM#:



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

RECEIVED
AUG 16 2001
OFFICE OF THE
ATTORNEY GENERAL

I. OFFICE INFORMATION

Robert Gregory Smith, MD, PA

Name of office

Ponte Vedra Beach 32082 St. Johns

City Zip Code County

R. Gregory Smith, MD

Name of Physician or Licensee Reporting

Same

Locating information for Physician or Licensee Reporting

3201 Sawgrass Village Circle

Street Address

(904) 285-5571

Telephone

ME0044578

License Number

II. PATIENT INFORMATION

[Redacted]

See Below

Locating information

Patient Identification Number

Excess abdominal skin & rectus

diagnosed muscle dehiscence s/p gastric

bypass & Postpartum changes

[Redacted]

Age Gender Medicaid Medicare

8/16/01

Date of Office Visit

abdominoplasty

Purpose of Office Visit

701.9, 728.84, 278.1

ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

8/16/01 - 1025 am

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)

See attached narrative summary

B) ICD-9-CM Codes

<u>none-anesthesia administration</u>	<u>Same</u>	<u>Arrythmia</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 800-899.9)

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 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.

<u>R. Gregory Smith, MD</u>	<u>ME 0044578</u>	<u>ACLS Certified</u>
<u>Louellyn Hale, CRNA</u>	<u>RN 3210392</u>	<u>ACLS Certified</u>
<u>Hollie Roberts, RN</u>	<u>RN 3394372</u>	<u>ACLS Certified</u>
<u>Tami Powell - MA</u>		

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)

Cardiac arrythmia not noted upon independent medical evaluation and EKG performed for clearance for surgical procedure.

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

ACLS treatment of arrythmia, re-evaluation by physician performing independent medical exam, referral to on call cardiologist at Baptist Beaches Medical Center for cardiac work-up.

V. *R. Gregory Smith, MD* ME 0044578
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

8/29/01
DATE REPORT COMPLETED

1430
TIME REPORT COMPLETED

Incident Report Narrative Summary

8/29/01

Patient: [REDACTED]

Physician: R. Gregory Smith, MD - ME0044578

Summary:

The patient is a [REDACTED] who was 6 years s/p gastric bypass surgery who presented for Type IV Abdominoplasty after independent medical evaluation by [REDACTED] family physician. The patient had lost greater than #100 LBS after gastric bypass surgery and was very active often working out 5 days a week. [REDACTED] also had significant abdominal muscle relaxation and dehiscence secondary to childbearing, which did not respond to working out. A preoperative EKG was performed and showed no changes since [REDACTED] previous EKG. [REDACTED] was cleared for the surgery to be performed under Level II (IV Sedation) and Tumescant Local Anesthetic.

The CRNA and myself performed an immediate pre-op exam and the patient was given final clearance for surgery. [REDACTED] was then taken to the OR Suite, monitored and lightly sedated. A small amount of local anesthetic was injected at the stab incision site to be used to instill the tumescant local anesthesia in the abdominal fat layer and tumescence of the abdomen was begun with Klein's Solution. A total of 420cc of this solution had been instilled when we noted a single PVC. The patient's EKG was observed and Lidocaine 50mg was readied to give IV if necessary. The patient then demonstrated occasional PVC's, which stabilized as quadrageminy. This was then treated with 50 mg lidocaine IV and the arrhythmia was suppressed. At this point I told the CRNA that the surgery was cancelled and to partially reverse the narcotic given, but not the Versed, since the patient was easily arousable. The arrhythmia was suppressed with the lidocaine but returned and an additional 50mg of lidocaine was given. The patient was questioned and asked if [REDACTED] had any chest pain or discomfort and [REDACTED] said none whatsoever. [REDACTED] vital signs were completely stable. An additional 50 mg of Lidocaine was given when the arrhythmia returned but the arrhythmia again returned as either bigeminy, trigeminy or occasional PVC's with stable vital signs.

The patient's evaluating physician, Dr. Bornhart was contacted and he was informed of the above and that the patient was completely stable. Arrangements were made for [REDACTED] to be seen by him that day and my nurse and myself transported the patient to his office. An EKG was performed on the same machine as used in the pre-op evaluation and the ectopy was noted but no evidence of ischemia. Dr. Bornhart recommended a cardiology consult and called the Cardiologist -on-Call at Baptist Beaches Medical Center, Dr. Hancock. She recommended that we take the patient to Baptist Beaches Medical Center ER so she could see her later for probable admission to perform a cardiac workup.

Narrative Summary

R. Gregory Smith, MD

My nurse and myself transported the patient to BMC-ER with the appropriate paperwork and [redacted] was checked into the ER. The ER physician, Dr. Don Smith, saw [redacted] one and one-half hours later and we were informed that the cardiologist would be in later to evaluate [redacted]. At this point I asked that [redacted] contact me after [redacted] evaluation. At approximately 1715 Dr. Hancock paged me and stated that it did not seem that [redacted] had had an MI and that this was probably a serendipitous uncovering of an occult conduction problem apparent from a strong family history of the same. She planned to do cardiac enzymes anyway and if negative would follow with an echocardiogram and stress test. The patient's cardiac enzymes were returned negative for MI. [redacted] had the echo and essentially a negative stress test, where the arrhythmia actually improved temporarily.

The cardiologist also scheduled the patient for a cardiac cath at the main Baptist Hospital under cardiologist, Dr. Shrank. The cath was performed and showed some occlusion but not requiring surgical intervention at this time. The patient was then started on several cardiac meds in an effort to control the arrhythmia and released to return to work and light exercise with plans in the future to do Holter monitoring.

The patient was seen by myself today and was doing well, feeling a little tired and still going to work. Routine vital signs showed the patient to still be in probable bigeminy with a pulse rate of 36 and Bp of 139/54. Dr. Hancock's office was informed. The patient will be rescheduled to be seen again by me in six weeks.



STATE OF FLORIDA
Jeb Bush, Governor

116
[Redacted]
01/29/01 11:13:02

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

Gainesville Radiology Group
Name of office
Gainesville 32601 Alachua
City Zip Code County
Mary Alderman, MD
Name of Physician or Licensee Reporting
Same as above
Locating information for Physician or Licensee Reporting

1026 S.W. 2nd AVE "A"
Street Address
(352) 372-6996
Telephone
ME 72835
License Number

II. PATIENT INFORMATION

[Redacted]
Local [Redacted]
Patient Identification Number [Redacted]
Diagnosis Acute cystitis

[Redacted] Medicaid Medicare
Age 8/29/01 Gender [Redacted]
Date of Office Visit [Redacted]
Purpose of Office Visit Diagnose Exam - IVP
ICD-9 Code for Diagnosis 57.4

III. INCIDENT INFORMATION

8/29/01 2:10:30 - 11am
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 No death

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

[Redacted] ye didactic [Redacted] at presented to our outpatient xray
office for an IVP. He of allergy only to PCM. After injection
of 100cc Omnipaque 300 nonionic contrast material pt develops
a warm flush over the next 15-20 min. [Redacted] complained
of feeling lightheaded, gradual onset of blurred vision &
headache. pt was assessed. [Redacted] BP 130/70 pulse 68
& regular & difficulty breathing; & tubes; blood sugar = 102.
[Redacted] began to complain of being sleepy. Over about 10 min
[Redacted] become more difficult to arouse, but still responded to
deep sternal rub and for some time to smelling salts.
When [Redacted] began to get sleepy - 911 called. - Paramedics
arrived within 5-10 min - pt transported to AGH ER.
Re-check of VS several times revealed BP 2/110-130 systolic & Pulse

B) ICD-9-CM Codes

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

unknown - temporarily related
to contrast injection
Accident, event, circumstances, or
specific agent that caused the injury
or event.
(ICD-9 E-Code)

it became non-responsive/comatose
Resulting Injury
(ICD-9 Codes 800-999.0) but stable
vs.

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.

ME 72835 Mary Alderman, MD, physician
 10586 Carol Wagner, RT, Radiographer performing exam
 32055 Pam Willis, RT, " " vital signs/monitoring
 31439 Lisa DeVault, RT, " " " "

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

Carol Wagner, RT, Pam Willis, RT, Mary Alderman, MD,
Lisa DeVault, RT

IV. ANALYSIS AND CORRECTIVE ACTION

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

cause unclear - temporarily related to contrast administration
but no signs of a true allergic reaction

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

- allergy screening as usual before contrast administration
- was on one-time contrast only

Mary Alderman
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
8/29/01
 DATE REPORT COMPLETED

ME 72835
 LICENSE NUMBER

1310
 TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
61 SEP -7 2000

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

Flora J. Danisi, MD
Name of office
Tallahassee 32308 Leon
City Zip Code County
Flora J. Danisi, M.D.
Name of Physician or Licensee Reporting

2626 Care Dr., #105
Street Address
850-877-2500
Telephone
ME-45387
License Number

Locality information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient Identification Number
Cosmetic
Diagnosis

[Redacted] Gender Medical History
Age 1-10-00
Date of Office Visit
Purpose of Office Visit
V50.1
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

11/10/00
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 responses)

Incorrect nasal packing count

B) ICD-9-CM Codes

<u>21.87</u>	<u>999.4</u>	<u>None</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 81-99.9)	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) Unknown

<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 Patient switched physicians	<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.

Flora J. Danjai, MD

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

No apparent cause or deviation from normal procedure found.

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

Have written a protocol

v. *[Signature]* ME 45387
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
08-29-07
 DATE REPORT COMPLETED TIME REPORT COMPLETED

B) ICD-9-CM Codes

[96.0, 154.3, V58.1

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-98.9)

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

Resulting Injury (ICD-9 Codes 800-998.9)

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

Supervisor of
 Dr. Chamber
 observed
 APRIL Baker RN DCN 2047492 Dr. Weeks ME 0063716
 LUCY Cobb RN 182726 Dr. Keitt ME 0025257
 Misty Sanders RN 18058 Dr. McCall ME 0066022
 ADA Adult Daycare UNITING PT. J

DAS INEAS + MCGHAT PONDAMON CHIST COMMISSIONS.

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

Above

IV. ANALYSIS AND CORRECTIVE ACTION

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

Patient multiple medical positions while on
 ACCIDENT FOR CAUSE INEFFECTIVE CHANGING. HAS HISTORY OF
 (L9911) PUNTE INEFFECTIVE CAUSE NOT ADAPT

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

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT: [Signature] ME 0063716
 LICENSE NUMBER

DATE REPORT COMPLETED 9/12/01

TIME REPORT COMPLETED

William T. McGarry, M.D.
Michaela G. Scott, M.D.
Frederick M. Weeke, M.D., FACP

1460 36th Street, Vero Beach, Florida

Name: _____ D.O.B.: _____ Dx: _____

Date: _____

Weight: _____

Temp: _____

Pulse: _____

BP: _____

MEDICATION:

JOHNSON, CHARLES

DOB: 08/11/29

09/12/01 - Mr. Johnson came in today for his third Taxol treatment. Mr. Johnson tolerated his first two cycles of Taxol well.

He walked in feeling well. Weight is 175 lbs. which is up only 2 lbs., pulse 70, blood pressure 126/61. Finger blood sugar test was 111.

The patient was given Decadron 4 mg and Tagamet 300 mg IV infused 45 minutes before Taxol. Ten minutes into his Taxol infusion, the patient suddenly stopped breathing and turned blue. Taxol was stopped.

The patient was not breathing, had no pulse, and CPR was initiated. An oral airway was then placed and an Ambu-Bag with oxygen support was used for ventilation. With the Ambu-Bag breath sounds could be heard in the chest.

The ambulance arrived within 8-10 minutes of the event. The patient was quickly intubated with good chest sounds. The patient was also given Atropine.

The patient was transferred to the hospital and admitted to the ICU. His wife has been notified.

FMW/sza



WA



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

Freddie McRae M.D.
Name of office
St. Petersburg, FL 33704 Pinellas
City Zip Code County
Name of Physician or Licensee Reporting
Locating Information for Physician or Licensee Reporting

1099 - 5th Avenue North, Suite 210
Street Address
(727) 820-7756
Telephone
28142
License Number

II. PATIENT INFORMATION

[Redacted]
Patient Name
Locating Information
Patient Identification Number [Redacted]
Diagnosis

[Redacted] [Redacted] Medicaid Medicare
Age 8-28-01 Gender
Date of Office Visit
Past surgical follow-up in response to patient's phone call
Purpose of Office Visit regarding incisional problem.
ICD-9 Code for Diagnosis
7/26/01 217
8/10/01 217
8/28/01 217
Location of Incident:
 Operating Rm Recovery Rm
 Other

III. INCIDENT INFORMATION

08-28-01
Incident Date and Time

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 a fibroadenoma of the left breast excised on 07/26/01. [Redacted] was seen in the office on 08/10/01 and had had some bleeding that had stopped. There was some slight ecchymosis and induration in the area. [Redacted] was started on Keflex and warm soaks and scheduled to come back in four weeks. [Redacted] completed the Keflex along with the warm soaks. [Redacted] then noticed there appeared to be a little gauze coming through the incision and a foul odor. [Redacted] called, we scheduled [Redacted] to come in right away. [Redacted] was examined on 8/28/01 in the office and there was some white fibers. The area was opened up and there was a gauze sponge that was removed. The area was irrigated with saline and flushed with 1/4% Marcaine. The hospital record for the initial surgery of 07/26/01 was reviewed and the sponge count performed by the nursing staff was shown as correct.

	7/26/01	217	191.60
	8/10/01	217	99024
B) ICD-9-CM Codes	8/28/01	217	99024

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

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 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.
 Beverly Callarik, Medical Assistant, in my office. She was present when I removed sponge.

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

Apparently, the operating room nursing staff did not accurately count and account for all sponges at the conclusion of the surgery.

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

From my standpoint, none has been taken in that I rely on the nurses to perform this task. As to the nurses, I am not certain what steps the hospital has taken relative to them. They are not employees of my office.

V. <u>J. Eddie L. McNeil</u>	28142
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
<u>10-9-01</u>	<u>10-2-0</u>
DATE REPORT COMPLETED	TIME REPORT COMPLETED

120



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
01 SEP -7 10:11:29

N/A

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14000,
Tallahassee, Florida 32317-6000

I. OFFICE INFORMATION

Flora J. Daniels, MD
Name of office
Tallahassee 32308 Leon
City Zip Code County
Flora J. Daniels, M.D.
Name of Physician or Licensee Reporting

2626 Care Dr. #105
Street Address
850-877-2500
Telephone
ME-45387
License Number

Locality information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient Identification Number
Cosmetic
Diagnosis

[Redacted]
Age 11-10-00 Gender _____ Medicaid/Medicare
Date of Office Visit
Purpose of Office Visit
V50.1
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

11/10/00
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 responses)

Incorrect nasal packing count

121



STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

10/11/2001
15:15 WA

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
Cancer Centers of Florida
City Zip Code County
Orlando FL Orange
Name of Physician or Licensee Reporting
Dr. Barry Belman
Locating information for Physician or Licensee Reporting

52 West Gore St.
Street Address
407-426-8484
Telephone
ME 056669
License Number

II. PATIENT INFORMATION

[Redacted]

[Redacted]

Locating information
Patient Identification Number
Lung Cancer - Bone mets
Diagnosis

10/11/2001
Date of Office Visit
MR Follow up
Purpose of Office Visit
161.3 288.0 295.9
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

10/11/2001 1140
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other parking lot

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)

While walking up ramp to enter facility
[Redacted] fell to the concrete and injured
spinal area. Pt. transported to hospital
because of low platelets due to chemotherapy
and to evaluate for any head injury.

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 800-989.9)

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.

no one - un-witnessed

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

*[redacted] was with [redacted] un-witnessed
by office staff*

IV. ANALYSIS AND CORRECTIVE ACTION

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

Unable to give cause - patient falls

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

*[redacted] was put in wheel chair and brought
to office with lacerations to face. 911 called
and responded. cannot be transported to ER.*

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

[Signature]
10/11/01

DATE REPORT COMPLETED

ME056669
LICENSE NUMBER

TIME REPORT COMPLETED



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT

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

APR 22 AM 11:52

N/A

122

I. OFFICE INFORMATION

CENTRAL FLORIDA ENT ASSOCIATES, P.A.
Name of office

3522 S. FLORIDA AVE STE C-10
Street Address

LAKELAND 33803 POLK
City Zip Code County

863-683-5454
Telephone

LANE R. MEYERSON, M.D.
Name of Physician or Licensee Reporting

ME 0070699
License Number

515 E GARDEN ST LAKELAND FL 33805
Locating information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

SENDRINGURAL HEARING LOSS
Diagnosis

10-9-01 Date of Office Visit
consultation for hearing aid Purpose of Office Visit
389.10 ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

10-9-01 10:00
Incident Date and Time

Location of Incident:
 Operating Room Recovery Room
 Other Reception Area

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)

The patient, [redacted] was accompanied to the office by [redacted] sister [redacted]. Both of them were following the audiologist through the reception area to the consultation office. [redacted] reported that [redacted] twisted [redacted] ankle (left) and began to fall. As the audiologist turned to speak to the patient she saw [redacted] falling head first into a door jam. [redacted] hit [redacted] head pretty hard and fell to the floor. When asked if [redacted] was okay, the patient replied, "I'm fine. However, [redacted] forehead (left side) looked red and swollen. The audiologist instructed the receptionist to call 911, which she did immediately. The patient was given a pillow to lay [redacted] head on, a bed roll to prop [redacted] foot up on and a sheet to cover [redacted]. EMT personnel arrived within 10 minutes and attended to the patient. At first, [redacted] did not want to be taken by ambulance to the hospital, [redacted] sister insisted that [redacted] go to the hospital.

[REDACTED] fell while
walking into the repair room
at the Central ENT office South
Side. [REDACTED] stumbled and hit [REDACTED]
head on the wall.

There were no bleeding
spots obviously.

[REDACTED]

[REDACTED]

9-9-01

(actual date of incident
was 10-09-01)
MGO

Fin @ 8:45 Normal sinus rhythm given verbal @ bedside + pt took it
Yuko @ bedside - pt awake alert oriented denied relief pt breathing very fast.
Reinforced to pt to slow breathing down pt refused to sleep to request a rate
(w 20-25 per minute. given 1 SL Nitro 2 rational reasoning to pt. pt
acknowledged understanding after 5 minutes pt denied and relief called
911 to respond to office. #20 gauge to @ A/C started pt SpO2 @ 45%
Time 9:10. Rest 24-26. Emp antibiotic transported via HRA to
ER. Called to speak to Cheryl Nurse to give her pt's procedure
and incident. Went to ER @ 1600 to check on pt - pt was being
d/c from ER - ER Chest Wall pain - given Darvocet and
sent home. pt Alert awake and able to walk in Room Nourished
me and stated that [redacted] felt better. Herrell



STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT

01 OCT 30 PM 12:04

NA

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

I. OFFICE INFORMATION

MICHAELA SCOTT & ASSOCIATES
Name of office

1460 36th STREET
Street Address

VERO BEACH 32960 INDIAN RIVER
City Zip Code County

561-562-7777
Telephone

APRILL BAKER RN
Name of Physician or Licensee Reporting

2047992
License Number

OFFICE
Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION



[Redacted]
Patient Identification Number

10/16/01 Gender [Redacted] Medicaid Medicare

Non-small cell lung cancer
Diagnosis

10/16/01 Date of Office Visit

Chemotherapy treatment Purpose of Office Visit

162.3 ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

10/16/01 1007
Incident Date and Time

Location of Incident:
 Operating Room Recovery Room
 Other: chemo room

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

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

pt. entered office 0855 IV started for Taxol / Carboplatin medication
chemotherapy. Oxycodone 50mg given - medication through lines
Taxol 300 mg 1 over 30 minutes given. Taxol started @ 0955
1007 pt. started to turn red @ 10 pmin in back, severe 1-10 (10)
Taxol stopped, O2 on Demerol 75mg IV given, Ativan 1mg given
all notified Dr. McBray in attendance - etc

B) ICD-9-CM Codes

V58.1 162.3
 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-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"/> 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.

APRIL BAKER 2047992 attending nurse
William McGarry MD BM 577 3177 attending 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)

possible reaction to chemotherapy (TAXOL)

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

Make sure patient is taking prophylactic (which he did)

[Signature] April Baker RN 2047992
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
10/16/01 1300
 DATE REPORT COMPLETED TIME REPORT COMPLETED

William T. McGarry, M.D.
Michaela G. Scott, M.D.
Frederick M. Weeks, M.D., FACP

1460 36th Street, Vero Beach, Florida

Name:

D.O.B.:

Dx:

Date: _____

Weight: _____

Temp: _____

Pulse: _____

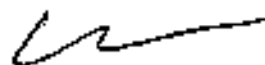
BP: _____

MEDICATION:

10/16/01 - CHEMOTHERAPY NOTE: [REDACTED] came in today to receive [REDACTED] Taxol, Carboplatin. The patient states [REDACTED] took [REDACTED] Decadron and Benadryl pre-med the night before. [REDACTED] received Tagamet 300 mg IV, Decadron 10 mg IV, and Benadryl 50 mg IV prior to having [REDACTED] Taxol started. The patient developed severe excruciating back pain almost immediately at the initiation of the Taxol. The patient was red in the face and Taxol was then discontinued. O2 2L was administered by face mask and the paramedics were called. Demerol 75MG and Ativan 1MG given by IV, pain relieved. Physical examination did not reveal any abnormal bowel sounds. EKG revealed bradycardia without any ST segment elevation. The patient was transferred to the hospital at that time.

While at the hospital I had ordered a CT scan of the abdomen and pelvis. This did not reveal any type of aneurysm or other abnormalities. The patient's pain was relieved with Demerol and Ativan and the cessation of the Taxol. The patient was admitted to the hospital overnight for cardiac enzymes to rule out a myocardial infarction.

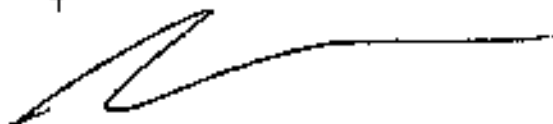
WTM/sza



Premedicate

Decadron 10mg
Benadryl 25mg IV
Tagamet 300mg IV
Zofran 32mg IV

Taxolene 60mg/m² IV
Carboplatin AUC = 6



10-18/01

pulse 40

97/54

95.7



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
OCT 30 PM 12:00 NA

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: Dr. Scott and Associates
City: Vero Zip Code: 32910 County: Indian River
Name of Physician or Licensee Reporting: Dr. Frederick Weeks
Locating Information for Physician or Licensee Reporting: Same

Street Address: 1460 36th Street
Telephone: 561-562-7777
License Number: _____

II. PATIENT INFORMATION

Patient Identification Number: _____
Diagnosis: Stage IV metastatic bladder CA
COPD, Laryngectomy

Date of Office Visit: 10/18/01
Purpose of Office Visit: Chemotherapy
ICD-9 Code for Diagnosis: 188.9 285.22 V58.1

III. INCIDENT INFORMATION

Incident Date and Time: 1705 10/18/01

Location of Incident:
 Operating Rm Recovery Rm
 Other: Chemotherapy 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. received Taxol chemotherapy, pt up to BR for BM returned to chair coughed, start of breath et greyish in color. Pt used MDI x2. S relief from shortness of breath. Pt up to BR again et shortness of breath increased. Dr. Weeks notified. Oxygen via trach started at 6L via simple mask, attempts made to cough et loosen congestion by pt, unsuccessful, Dr. notified. Per Dr. Weeks order ambulance-91 called et pt. transferred to hospital.

B) ICD-9-CM Codes

V58.1 1889 285.22

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"/> 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 unexplained 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.

Lucy Cobb RN - Administered Chemotherapy, assisted in Recovery
April Baker CRNA, CNA - Administered Anest, monitor, assisted in Recovery
Dr. Frederick Weeks - attending Physician

F) List witnesses, including license numbers if licensed; 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)

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

V. [Signature] SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

10/18/01 DATE REPORT COMPLETED 1800 TIME REPORT COMPLETED

William T. McGarry, M.D.
Michaela G. Scott, M.D.
Frederick M. Weeks, M.D., FACP

1460 36th Street, Vero Beach, Florida

Name: _____ D.O.B.: _____ Dx: _____

Date _____

Weight _____

Temp. _____

Pulse _____

BP _____

MEDICATION:

10/18/01 - [redacted] is a [redacted] with COPD, and a past history of a tracheostomy in '95 for head and neck cancer. [redacted] is currently receiving weekly Taxol for stage IV urothelial carcinoma.

Today [redacted] received [redacted] Taxol without complication. [redacted] dose of Taxol today was 100 mg. On [redacted] way out of the office, [redacted] went to the rest room and came out and was coughing. Because of [redacted] laryngectomy, [redacted] has difficulty communicating, but it appears that [redacted] had a mucus plug. For 30 minutes we tried some excess hydration, and [redacted] Albuterol meter dose inhaler. With this [redacted] was able to cough up some mucus plugs, but not a significant amount. [redacted] appeared to be much more comfortable on oxygen.

The patient's daughter was present. She said this happens frequently at home. Frequently at home [redacted] gets mucus plugs caught. This happens more than one to three times a day. At home [redacted] uses a nebulizer followed by intubation of [redacted] trach with a suction catheter. We do not have nebulizers and do not have a suction trach here.

Because of [redacted] obvious decreased symptoms while on oxygen, I did not feel that it was safe for [redacted] to get in the car and drive to [redacted] house as [redacted] and [redacted] daughter wished. Instead I felt it was in the patient's best interest for [redacted] to be transferred to the emergency room.

I explained to the patient and [redacted] daughter that because of the lack of oxygen, I feel that [redacted] needs to be transported on oxygen. [redacted] understands and [redacted] and [redacted] daughter agree.

I then called and spoke with Dr. Dudley Teel in the emergency room. I explained the situation. The patient will arrive there for nebulizers and suctioning.

At the time of discharge, the patient is stable, alert, and actually appears slightly more comfortable.

FMW/sza



William T. McGarry, M.D.
Michaela G. Scott, M.D.
Frederick M. Weeks, M.D., FACP

1460 36th Street, Vero Beach, Florida

Name:

D.O.B.:

Dx:

Date _____

Weight _____

Temp. _____

Pulse _____

BP _____

MEDICATION:

10/25/01

Wt. 170 lbs.

Insulin

Metamucil

10/18/01 - ADDENDUM:

██████████ was seen in the Indian River Memorial Hospital Emergency Room. Dr. Teal had respiratory therapy standing by. The patient had a single nebulizer and trach suctioning and was immediately better and ready for discharge. ██████████ was then discharged to home.

FMW/sza



C&C . 4/0 of diarrhea



126

RECEIVED
CONSUMER SERVICES UNIT
01 OCT 31 PM 12 26



STATE OF FLORIDA
Jeff Bush, Governor



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14000,
Tallahassee, Florida 32317-0000

N/A

OFFICE INFORMATION
Cancer Centers of Florida
Ocala
33701 Seminole
Donna Van Dater, MD
Name of Physician or Licensee Reporting

508 W. Maitland Ave #204
407 339-6974
RN 3064032

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Locating Information [Redacted]
Patient Name [Redacted]
Diagnosis: MDIS

[Redacted]
Age: 61
Sex: M
Reason for Office Visit: History of Ethanol
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

10/24/98 10:30
Incident Date and Time

Location of Incident
 Operating Rm
 Other: Chemotherapy

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 given PD Benedryl 50mg, 24g of Angio started in OR.
Infusion of Anzemet 100mg + Zantac 50mg w/ 250cc NS
started. Pt received approx 10cc of infusion. Pt felt
dizziness. Pt became unresponsive, called Dr. Ke Smer
DO. Stopped IO, took BP 94/98 Pulse 40. Pt arrested.
Dennis MD CR IV started of NS 1000 wide open. 911
called. Pt states feeling better. Dr. [Redacted]
Paramedics arrived. BPP Pt taken by stretcher to
ICU

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 800-999.9)
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C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete responses)

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 injury 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 neurologized, 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.

Kenneth M. Simon, DO # OS0007658
Called to examine pt.

F) List witnesses, including license numbers if licensed, 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)

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

V. [Signature] 3064032
 SIGNATURE OF PHYSICIAN/LICENSER SUBMITTING REPORT LICENSE NUMBER
10/2/14 11/15
 DATE REPORT COMPLETED TIME REPORT COMPLETED

107



STATE OF FLORIDA
Job Bush, Governor



RECEIVED
CONSUMER SERVICES UNIT

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT NOV - 8 PM 12:17

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

NA

I. OFFICE INFORMATION

Geffen Cancer Center
Name of office

981 37th A
Street Address

Vero Beach 32900 Indian River
City Zip Code County

(561) 770-5800
Telephone

Journey Geffen, MD
Name of Physician or Licensee Reporting

ME0051697
License Number

VERO BEACH, FL
Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Locating Information

[Redacted] Age Gender Medicaid Medicare

[Redacted]
Patient Identification Number
Prostate CA & LN Mets
Diagnosis

10-29-01 Date of Office Visit
Routine Chemo Follow-up Purpose of Office Visit
185 ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

10/29/01 1500
Incident Date and Time

Location of Incident
 Operating Room Recovery Room
 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 presented for routine appt today + developed sudden onset
of chills and rigors. Vitals were normal + pt had no fever.
Pt became short of breath with increased weakness.
After determining that he was too weak to transport
himself, 911 was called + he was transferred by
ambulance without incident, to INDIAN RIVER MEM'l HOSPITAL

B) ICD-9-CM Codes

None
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

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

None
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 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.

Dr. Jeremy R. Griffin ME 0051697
Natalie Jones PA-C PA9101729
Connie Ozment LPN 1358621

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

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

V.

Jeremy R. Griffin
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
11/20/10
 DATE REPORT COMPLETED

ME 0051697
 LICENSE NUMBER

5:00
 TIME REPORT COMPLETED

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
01 NOV 26 AM 11:24

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

I. OFFICE INFORMATION

128
bound by you
credit
Oology Center of Florida
Name of office
Pompano Beach 33060 Broward
City Zip Code County
Craig Kerns
Name of Physician or Licensee Reporting
Same
Locating information for Physician or Licensee Reporting

550 SW 3RD ST
Street Address
954 941-3333
Telephone
NE 0043959
License Number

Check
Keep piece of
for review
NOTE: Filing actual report

II. PATIENT INFORMATION

[Redacted]
[Redacted]
[Redacted]
Patient Identification Number
Vasovagal Reaction
Diagnosis

[Redacted]
Age 11-16-01 Gender Male
Date of Office Visit
Collagen injection
Purpose of Office Visit
T&E
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

11-16-01 2:30 PM
Incident Date and Time

Location of Incident
 Operating Rm Recovery Rm
 Other Cytology Room

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

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

after undergoing cystoscopy with collagen injection
pt became nauseated with diaphoresis. Pt was
concerned about something [redacted] at Wash
Ambulance called when condition didn't resolve
in approx 1 hr. Pt taken to N. Ridge E.R
and discharged that day

B) ICD-9-CM Codes

51715 788.32
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.0)

51715 788.32
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 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 checked="" 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.

Attending urologist - Craig Herman ME 0043959

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

Barbara Soto - medical assistant
Bertha Medina - medical assistant

IV. ANALYSIS AND CORRECTIVE ACTION

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

Exact cause unknown. Pt had a negative Collagen skin test prior to procedure.

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

It was treated in the office initially & was triaged to an acute care facility because symptoms persisted.

V. Craig Herman ME0043959
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

11-19-01
DATE REPORT COMPLETED

5PM
TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
NOV 26 PM 12:05

NA

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

I. OFFICE INFORMATION

129
SPACE COAST MEDICAL ASSOCIATES
Name of office
TiNSVILLE 32976 BREVARD
City Zip Code County
Salomon Zimm, M.D.
Name of Physician or Licensee Reporting

850 CENTURY MEDICAL DRIVE
Street Address
321-268-4200
Telephone
ME0050524
License Number

Locating information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient Name
[Redacted]
Locating Information
[Redacted]
Patient Identification
[Redacted]
Diagnosis Polycythemia Vera

[Redacted]
Age
11-14-01
Date of Office Visit
11-14-01
Purpose of Office Visit
2384
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

11-14-01 11:55/pm
Incident Date and Time

Location of Incident:
 Operating Rm
 Recovery Rm
 Other Physician 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)

11-14-01 10:40/am - ARRIVED FOR phlebotomy - IV STARTED @ 500 cc 0.9 NS
FOR hydration - phlebotomy started AFTER 250cc INFUSED AT 11:20/am -
APPROX 350 cc OBTAINED FROM (phlebotomy) (COMPLETED AT 11:50 am -)
AT 11:52/am pt said "I DON'T FEEL RIGHT" THEN NO NAUSEA THEN
PT LOST CONSCIOUSNESS - IV LINE STILL IN PLACE & RATE WIDE OPEN -
DR. ZIMM NOTIFIED - ADDITIONAL IV LINE STARTED @ 1000 0.9 NS RATE
WIDE OPEN IN OTHER ARM - (while 911 being called by FRONT DESK -)
PARAMEDICS ARRIVED AT APPROX 12:00pm - PT RESPONDED BY OPENING EYES - BP 140/80
PT NOT RESPONDING VERBALLY - PT TAKEN TO PARISH MEDICAL CENTER ER

Tom M. [Signature]

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-Code)	Resulting injury (ICD-9 Codes 800-999.9)
Abil. Botomy		

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.

TERRY McFARLAND R.N. - RN 9180729 - performed phlebotomy
 PR. ANDERSON AND PEE POLY - PR. ANDERSON

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

Kathy Hudson RN - RN 316662

IV. ANALYSIS AND CORRECTIVE ACTION

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

Recognition of Therapeutic Phlebotomy

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

W. fluids given and patient transferred to Hospital Emergency Room

V. Sponson Emma M.D. 5024
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
11/14/01 17:00
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
01 NOV 27 PM 12:10

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

NA

I. OFFICE INFORMATION

Florida Community Cancer Ctr
Name of office

725 Virginia St
Street Address

Dunedin 34698 Pinellas
City Zip Code County

(727) 733 9364
Telephone

Linda Montgomery RNOCN
Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

725 Virginia St Dunedin FL 34698
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

Age Gender MARITAL STATUS

11/15/01

chemo therapy
Date of Office Visit

945.0 anaphylactic reaction
Purpose of Office Visit

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

109.5 Hemicytosis
Diagnosis

III. INCIDENT INFORMATION

11/15/01 11:20 AM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other: Chemotherapy 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. got itching hands. Face flushed red. Then periorbital
edema started. Within 30-60 seconds of onset of
above pt. got dyspnea + chest pain. 911 EMS
notified. O₂ applied. Bradycardia 25mg IV; Solu-medrol
125mg IV given per Dr. Joppert's order. Condition
worsened over the next 3-4 minutes. Pt. becoming
unresponsive. Epinephrine 1:1000 given IV per
Dr. Joppert. EMS arrived within 5 minutes of notification.
Patient was responsive to sternal VS when transported
out of office by EMS to Hance Dunedin Hosp. ER.

1 of 2 pages
Form # DH-MQA1030, created 2-00; revised 9-6-01

Patient stated that [redacted] was
allergic to strawberries as a child. [redacted] drank a
strawberry EAsure approx. 30-45 minutes before react

B) ICD-9-CM Codes

V58.1 Chemotherapy 995.0 anaphylactic reaction
 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) 995.0 2° to ← strawberry drink or chemotherapy
 Resulting injury None (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>Meade 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.

Linda Montgomery RN OCN RD 3034777
Callista Barabasz RN OCN RD 2962452
Marcus Joppert MD ME 73531

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

Victoria Riley, Mary Sue Hanna & patients in the change room

IV. ANALYSIS AND CORRECTIVE ACTION

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

Probable - allergic reaction to strawberries.
Chemotherapy had been infused IV over 45 min. Reaction did not occur until the end of infusion.

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

Strawberry allergy noted in patient's chart
Physician to determine course of action related to chemotherapy treatments.

v. Linda Montgomery RN OCN
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
11/19/01 300 PM
 DATE REPORT COMPLETED TIME REPORT COMPLETED

MW 11-20-01
Jac



STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
01 NOV 27 PM 12:09

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

pit

I. OFFICE INFORMATION

Florida Community Cancer Center
Name of office

725 Virginia Street
Street Address

Dunedin, FL 34628 Pinellas
City Zip Code County

(727) 733-9364
Telephone

Callista Garrabrant
Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

725 Virginia St. Dunedin FL 34628
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

11/07/01
Patient Identification Number
Myeloproliferative Disorder
Diagnosis

11/07/01
Date of Office Visit
Monthly Blood Work (CBC)
Purpose of Office Visit

ICD-9 Code for description of incident
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11/07/01 @ 8:40 AM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other Office parking lot

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 to office for monthly blood work (CBC). [Redacted] complained of "not feeling well" since 11/01/01. Also, complained of stomach pain. Advised by Callista Garrabrant RN to go directly to Mease Dunedin Hospital ER. This RN escorted patient to [Redacted] car but patient appeared too ill to drive & escorted to passenger seat. Staff called 911. Linda Montgomery RN also came to assist patient who became white, diaphoretic and started moaning loudly. [Redacted] pulse was weak but rapid. [Redacted] then became non-responsive and we could not feel [Redacted] pulse. EMS arrived at this point. Linda Montgomery gave them report and helped move [Redacted] out of car to the ground. Paramedics assumed [Redacted] care at this point and then transferred [Redacted] to Mease Dunedin Hospital ER.

B) ICD-9-CM Codes

N/A 780.09 Loss of consciousness unknown
 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes D1-89.9) 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) 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 <u>admitted to Newbury Hospital</u> Name of facility to which patient was transferred <u>Newbury 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.

Callina Garrahan RN lic. # RN 2942652 Referred pt. to ER,
assisted [redacted] to car, and called 911 and stayed with patient until EMS
Linda Montgomery RN assisted above RN, monitor vital signs
Lisa RN 3034772 reported to paramedics, helped move patient to
ground & paramedic.

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

Vickie C. Riley, Medical Assistant

IV. ANALYSIS AND CORRECTIVE ACTION

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

[redacted] ill prior to coming for blood work, condition worsened when
assisted to [redacted] car requiring 911 assistance.

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

- 1) Referred to nearby ER (Newbury Hospital)
- 2) 911 called when [redacted] appeared too ill to drive
- 3) Assisted [redacted] until paramedics arrived.

Shawn M. Howard ME 26552
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
11/16/01 5:00 PM
 DATE REPORT COMPLETED TIME REPORT COMPLETED

Handwritten signature and date:
John
11/20/01

RECEIVED
CONSUMER SERVICES UNIT
DEC -3 PM 12:04

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

Laser Eye Center
Name of office
Miami 33134 Dade
City Zip Code County
Joseph Kurstin, M.D.
Name of Physician or Licensee Reporting

3737 S.W. 8th Street, Suite 101
Street Address
(305) 461-2400
Telephone
ME 12092
License Number

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient Name
[Redacted]
Locating Information
Patient Identification Number
Retinitis
Diagnosis

[Redacted] 1/26/01 Gender Medicaid/Medicare
Date of Office Visit
Laser Eye Surgery
Purpose of Office Visit
367.20
ICD-9 Code for Diagnosis

NOT
ACCURATE

NOT
ACCURATE

NOT
ACCURATE

Topical
antibiotic

III. INCIDENT INFORMATION

1/26/01
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)

See attached incident report.

B) ICD-9-CM Codes:

657.60
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 checked="" 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 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.

Joseph Kurstin, M.D., performed surgery
Martiza Gorrin - Assistant - brought in wrong patient.

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

Vilma Hernandez, certified Ophthalmic Technician, #66977

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analyze (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)

V.

Joseph Kurstin
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 12092
LICENSE NUMBER

4/27/01
DATE REPORT COMPLETED

9:30 AM
TIME REPORT COMPLETED

ANALYSIS:

In this case I appropriately asked the patient if [redacted] name was [redacted] prior to performing the surgery to verify I was treating the right patient. The patient indicated that was [redacted] name. I also discussed the procedure that I was going to perform. During the procedure, I referred to the patient by name several times when speaking with [redacted]. Unfortunately, the patient did not tell me [redacted] name was not [redacted] until the laser procedure had been completed on the right eye. I completed the correct procedure on the left eye, then discussed the fact that surgery in [redacted] right eye was for a different prescription and that it was easily remediable, both with patient and [redacted]

CORRECTIVE ACTION:

I tried to take the appropriate steps to identify this patient. The error would not have occurred if the patient had responded that the name that I called [redacted] was incorrect. I take pride in running my practice correctly and I have never had a situation like this in the past. To ensure that a situation like this does not occur again, we are providing patients with name tags. In addition, the patient is asked directly three different times if his/her name is correct: by the technician bringing the patient into the room, by the Chief Technician assisting surgery and by myself prior to doing the surgery. The patient's chart is checked by all three comparing the name on the chart with the name in the patient's name tag.

133

CITRUS HEMATOLOGY AND ONCOLOGY CENTER
801 MEDICAL COURT EAST
INVERNESS, FLORIDA 34462 (CITRUS COUNTY)
TEL. 352-637-4490 FAX 352-637-3987

RECEIVED
CONSUMER SERVICES UNIT

01 DEC -6 AM 11:58

NYA

PHYSICIAN OFFICE INCIDENT REPORTING FORM

PATIENT'S NAME [REDACTED]

ADDRESS [REDACTED]

CITY/STATE/ZIP [REDACTED]

GENDER [REDACTED] DATE OF BIRTH [REDACTED] AGE [REDACTED]

[REDACTED] PATIENT ID# [REDACTED]

ICD9 CODE/DIAGNOSIS 202.80 DATE OF VISIT 11/15/2001

PURPOSE OF OFFICE VISIT Hospital follow-up

INCIDENT DATE AND TIME: Thursday, November 15, 2001 at 10:30 A.M.

LOCATION OF INCIDENT:
 EXAM ROOM CHEMOTHERAPY ADMIN ROOM OTHER Blood Draw Area

IF THE INCIDENT INVOLVED A DEATH, WAS THE MEDICAL EXAMINER NOTIFIED? N/A
 YES NO

WAS AN AUTOPSY PERFORMED? YES NO N/A

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

Thursday, November 15, 2001 at approximately 10:30 A.M., Tiffany was performing a blood draw on [REDACTED] (in blood draw area). [REDACTED] was speaking coherently when suddenly started sweating profusely and becoming incoherent and lethargic. [REDACTED] stated that [REDACTED] has been having diarrhea, sweating and

(PLEASE SEE REVERSE SIDE FOR CONTINUATION)

ICD-9-CM CODES

Surgical, diagnostic or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.8)

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: IVP's,

Pulse oximetry and labs.

is diabetic, has had [redacted] medications, and did not eat well. IVF's started secondary to blood pressure dropping, [redacted] drank juice and is more alert but blood pressure continuing to drop. Ambulance called and patient sent to the Citrus Memorial Hospital emergency room.

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)

Nilsa Rosario

Tiffany O'Connor

Eva Henriquez

Dr. Dela Cruz

LIST ANY WITNESSES NOT IDENTIFIED ABOVE

ANALYSIS AND CORRECTIVE ACTION:

(Apparent cause) of this incident: Patient too sick to be taken care of in the office.


Describe corrective or proactive action(s) taken: Patient sent to emergency room at Citrus Memorial Hospital.

NAME OF PHYSICIAN Dr. Dela Cruz LICENSE NUMBER MBB1376

ADDRESS 801 Medical Court East

CITY/STATE/ZIP Inverness, FL 34452

SIGNATURE OF PHYSICIAN
(OR LICENSEE SUBMITTING THIS REPORT)



DATE REPORT COMPLETED 11/20/01 TIME REPORT COMPLETED 9:00 A.M.



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

RECEIVED
CONSUMER SERVICES UNIT
01 DEC - 6 PM 12: 08

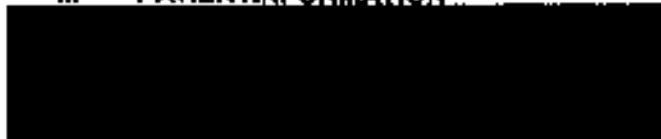
I. OFFICE INFORMATION

134
Florida Community Cancer Center
Name of Office
Brooksville, 34613 HERNANDO
City Zip Code County
Richard Grandino, M.D.
Name of Physician/Licensee Reporting

11307 Chetler Blvd.
Street Address
352-596-926
Telephone
ME0049404
License Number/ID/Registration Number, if applicable

Patient's address for Physician/Licensee Reporting

II. PATIENT INFORMATION



Age 11/26/91 Gender Medicaid/Medicare
Date of Office Visit 12/5/01
Purpose of Office Visit 925-02
ICD-9 Code for description of incident
Level of Surgery (I) or (II)

Patient Identification Number
Lung Cancer
Diagnosis

III. INCIDENT INFORMATION

11/26/01
Incident Date and Time

Location of Incident:
 Recovery Room
 Facility
 Other

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

A) Describe circumstances of the incident (narrative)

(Use additional sheets if necessary for complete response)

Patient was being held in submergence gown (up 50 mg) face + eyes became flushed. BP 190/100. States feels like everything is going to leave. clasternal tightness. Saline running to incident. Patient became cold and clammy, BP dropped to 70/50, 60/30, 911 called. Patient placed on O2 @ 4LNC. Patient slowly began to feel better BP ↑ 90/60. Approx. 15 MIN LATER BP ↑ 162/80 EMS Arrived & transported patient to Oakhill hospital ER.

GMW
11-29-01
Pet

B) ICD-9-CM Codes

U58.1

995.2

995.2 / 458.8

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-98.9)

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

None 02, 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 <u>observation</u> Name of facility to which patient was transferred <u>CARLE 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 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.

Linda White, R.N., OCN - 3180 002 - RN caring for patient

Barbara Cera, RN, OCN - 601508 - RN in room assisting E Patient

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 the incident (Use additional sheets as necessary for complete response)

Patient had drug reaction to Solumedrol

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

Patient will be given Solumedrol very slowly next change treatment if still reacts Solumedrol will be deleted from treatment.

v. Richard R. Carabonnet HEC0019404

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

11/27/01 4:00 PM
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

RECEIVED
CONSUMER SERVICES UNIT
01 DEC -6 PM 12: 08

N/A

I. OFFICE INFORMATION

Name of Office: FLORIDA COMMUNITY CANCER CENTER
City: BONNAYVILLE Zip Code: 34613 County: HERNANDO
Name of Physician or Licensee Reporting: MICHAEL CAERADONIA, M.D.

Street Address: 11307 Cortez Blvd.
Telephone: 352-596-1926
License Number & Offsetting License Number, if applicable: ME0049404

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

Age: 11-14 Gender: M Medical/Medicare:
Date of Office Visit: 12/6/01
Purpose of Office Visit: DISKIT INJECTION - Q0136
ICD-BC Code for description of incident:
Level of Surgery (I) or (II):

Patient Identification Number: NON-HODGKINS LYMPHOMA
Diagnosis:

III. INCIDENT INFORMATION

Incident Date and Time: 11-14-01 12:00pm

Was an Incident? Reporting Form Recovery Form
 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)

[Redacted] was found lying face down on the cement sidewalk outside the office building. [Redacted] was present and both [Redacted] and [Redacted] said [Redacted] had tripped and fallen. [Redacted] NOSE, chin, knees and elbows were bleeding. There was a laceration on nose wound + EMS was called. After EMS arrived it was cleaned and placed in neck brace + put on board and transferred to the hospital. This event occurred after the patient was leaving facility.

B) ICD-9-CM Codes

174.4
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

300.9
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)

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)

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 object... 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 & Treat</u> Name of facility to which patient was transferred <u>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
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E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

William Assad, MD ME 48722 Cared for patient
Kelli Mosher, PA-C PA 2329 Cared for patient
Linda Hartwick, CNA 09701434892A Cared for hospitalized patient

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

Margaret McDonnell RN 3006602 Phoned police

IV. ANALYSIS AND CORRECTIVE ACTION

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

Patient expressing suicidal ideation was improperly transferred to hospital by Receptionist / CNA / Pt. Arrived safely & was admitted.

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

Employee received written counseling & counseling advising her of improperly transferring patient and advising her to allow physician to make such patient care decision

v. Kelli C. Mosher PA 2329
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
11/30/01 5:45p
 DATE REPORT COMPLETED TIME REPORT COMPLETED

AW 12-3-01

RECEIVED
CONSUMER SERVICES UNIT
PH 12:07

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

GEFFEN CANCER CENTER
Name of office

981-37th PLACE
Street Address

VERO BEACH FL INDIAN RIVER
City Zip Code County

561-770-5800
Telephone

GEFFEN, JEREMY R. MD
Name of Physician or Licensee Reporting

ME 0051697
License Number

VERO BEACH, FL
Locating information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

Age 12-5-01 Gender _____ Medicaid/Medicare _____

Patient Identification Number _____
Diagnosis Pancreatic Ca.

Date of Office Visit Follow up
Purpose of Office Visit 1570
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

12/5/01 2^{pm}
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other CHIMUTHEATRY

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 IS A DIABETIC TAKING AM INSULIN LUNCH
WAS DELAYED. AT 2^{pm} PT WAS FOUND TO BE
FADING WITH UNRESPONSIVENESS. CALLED CLERK TO CHECK
CHECK TAKEN WITH READING OF "LOW". ORANGE
JUICE, FOLLOWED BY COKE SODA. IV FLUIDS OF D5W
STARTED "911" ACTIVATED. PT ALERT AND RESPONSIVE BY SSG
WHEN AMBUANCE ARRIVED HOWEVER TAKEN TO HOSPITAL (JRMH)
ER FOR FOLLOW UP. DAUGHTER PRESENT. PT AND DAUGHTER
BEING HYDRATED & 1000N NS FOR DEHYDRATED AWAITING DAUGHTER PICK UP TO

B) ICD-9-CM Codes

251.2

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 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.

patient [redacted] JEANNINE SMITH RN 299512
 MAUREEN VAN NAME RN 1875252 @ GEFLEN CANCER CENTER

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

JANIE OZMET LPN

IV. ANALYSIS AND CORRECTIVE ACTION

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

hypoglycemia

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

orange juice + coke soda

V. JAGGERS ME 0051697
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
 12-501 3:30 pm
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
01 DEC 13 PM 1:37

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

138

I. OFFICE INFORMATION

Full (Fl. Community Care Cr.)
Name of office

Bradenton 34209 USA
City Zip Code County

Dorian Bell
Name of Physician or License Reporting

Physician's address for Physician or License Reporting

6001 21st Ave. W.
Bradenton, FL 34209

Street Address

941 792. 1801

Telephone

License Number & office registration number, if applicable

II. PATIENT INFORMATION



Age 12/7/01 Gender Medicaid Medicare

Date of Office Visit

Chemotherapy treatment

Purpose of Office Visit

Patient Identification Number

Lung Cancer

Diagnosis

ICD-9 Code for description of incident

Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

12/7/2001 @ 1648
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 responses)

PT. STARTED CARBOPLATIN (chemotherapy tx) AT 1640. AT 1648,
patient reporting burning sensation in the tongue, face,
lower extremity. ALSO reports dull pain on lower
of chest. Patient is fully awake, alert. Face flushed.
SP 120/82. CARBOPLATIN STOPPED IMMEDIATELY. Normal saline
solution infused. DR. NOTIFIED. ALL OF DOSE. SOME
MEDICAL RT MA AND BRADLEY 50 MG IV GIVEN. PATIENT
WAS TRANSPORTED TO STATE ER VIA EMS, CONDITION STABLE

B) ICD-9-CM Codes

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

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

Hypersensitivity reaction
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, if discharged home</u> 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 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.

LORETTA MOLLON - RN LP 1325192
Frank Galotti - Chemd RN 0965772
Blaine DeLong - MD ME0073368

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

Lisa Cunningham RN 1775712

IV. ANALYSIS AND CORRECTIVE ACTION

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

Hypersensitivity reaction to Coloblation

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

Continue to keep emergency drugs in the clinic
Written protocol for hypersensitivity reaction

V.

[Signature]
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
12/21/01 DATE REPORT COMPLETED
1745 TIME REPORT COMPLETED

ME0073368
 LICENSE NUMBER



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT
DEC 13 PM 2:19

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

*Band's info
accidents
HSP Dr. [unclear]*

139

*Death
of
[unclear]*

I. OFFICE INFORMATION

Name of office: John Q Stauffer MD PA
City: Tampa Zip Code: 33609 County: Hillsborough

Name of Physician or Licensee Reporting: John Q Stauffer MD
Reporting Information for Physician or Licensee Reporting: 2919 Swann # 205 Tampa FL 33609

Street Address: 2919 Swann # 205
Telephone: 813-870-3971
License Number: ME 31349

*I called
office of
see cons
pediatric
MD
[unclear]*

II. PATIENT INFORMATION

[Redacted Patient Information]

Patient Identification Number: Rectal Bleeding
Keywords: Rectal Bleeding

[Redacted Patient Information]

Date of Office Visit: 11/29/01
Purpose of Office Visit: Colonoscopy
ICD-9 Code for Diagnosis: 562.11

NOT
acc.
[unclear]

III. INCIDENT INFORMATION

Incident Date and Time: 11/29/01 1:20/P

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)

See attached progress notes, letters and sheets



PALMA CEJA MEDICAL GROUP

December 3, 2001

Martin Marks, M.D.
3225 S. MacDill Avenue
Suite 117
Tampa, FL 33629

RE: [REDACTED]

Dear Marty:

[REDACTED] colonoscopy on 11/29/01 was limited because of [REDACTED] development of respiratory distress and a low blood pressure. This patient was resuscitated in the office with oxygen and also given Lasix and some atropine. Fire Rescue was called, and [REDACTED] was transported to Memorial Hospital Emergency Room.

In the Emergency Room, [REDACTED] continued to have cardiopulmonary distress and sustained a cardiac arrest. [REDACTED] was resuscitated from this and was intubated successfully at this time. As you recall, Fire Rescue attempted an intubation in the office and this was unsuccessful, having intubated the esophagus, at which time some air was pumped into [REDACTED] abdominal cavity.

After successful intubation in the hospital, chest x-ray revealed that the endotracheal tube was properly placed but that there was free air under the diaphragm. Because of this, [REDACTED] was taken to surgery by Dr. Temple at which time a diverting colostomy and gastrostomy were performed. This led to significant improvement in [REDACTED] abdominal distension, and at least transiently, improvement in [REDACTED] cardiopulmonary status.

Unfortunately, the patient, after being transferred to the Intensive Care Unit, sustained another cardiac arrest and could not be successfully resuscitated.

I will keep you informed as to the results of the Medical Examiner's evaluation.

Sincerely yours,

John Q. Stauffer, M.D.

JQS:MDAkv

JOHN Q. STAUFFER, M.D.
Internal Medicine/Gastroenterology

2010 SWANN AVENUE SUITE 100 TAMPA, FLORIDA 33606-1010 (813) 70-8877



PALMA CEJA MEDICAL GROUP

December 7, 2001

Martin Marks, M.D.
3225 S. MacDill Avenue
Suite 117
Tampa, FL 33629

RE: [REDACTED]

Dear Marty:

As we discussed, [REDACTED] underwent a postmortem examination by the Medical Examiner.

My discussion with the Medical Examiner, after she completed the examination, indicated that she found no trauma to the colon that would explain the air under the diaphragm. Careful inspection of the area that was examined endoscopically showed no obvious perforation or tear of the colonic mucosa. The cause of the air in the diaphragm is not clear at this time.

The patient was found to have significant coronary disease, and it is possible that [REDACTED] sustained a myocardial infarction or perhaps some congestive failure that then progressed to a cardiac event.

As we discussed, the procedure itself was terminated when [REDACTED] appeared to be having some respiratory discomfort, and we did not do any biopsies or removal of any tissue during the course of the procedure that could have precipitated this event.

Again, I am deeply saddened by this event.

Sincerely yours,

John Q. Stauffer, M.D.

JQS:MDakv

JOHN Q. STAUFFER, M.D.

Internal Medicine/Gastroenterology

2818 SWANN AVENUE, SUITE 208/TAMPA, FLORIDA 33609 (813) 970-3271

B) ICD-9-CM Codes

413.9

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-Code)

Resulting injury (ICD-9 Codes 900-999.9)

C) List any equipment used if directly involved in the incident ~~Engineering, Medical Records, Dental Laboratory,~~
(Use additional sheets as necessary for complete responses)

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: <ul style="list-style-type: none"> <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.

William Hays RN 251575-2 Blue Team Team member Karla Glatfelter RN 2620102 Blue Team member
 Michelle Foster 47757 Blue Team member, nurse, NIA, NIA, NIA
 Jill DeBruin RN 1759902 Blue Team member
 B. Campese RN 1759902 Blue Team member

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

Rebecca Schultze

IV. ANALYSIS AND CORRECTIVE ACTION

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

New onset of sexual activity. Unusual relationship between adult & sexual activity and children. Street Team.

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

PT monitored, managed and transported to hospital.

V. SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

251575-2
LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

Dr. Anthony Hasam

(305) 267-3434

office hours 10am - 6pm

- message is in Spanish then in English

• Dr. C would like to speak to abt. re procedure (see attached) - specifically abt anesthesia used (general vs local)

• AC left vm on 2/28 @ 9:15 AM,

March 5 = 10 AM
Patricia = Call back on

MIRAMAR FL

Richard Gonzalez CRNA

Robert Weir CRNA

Call to Miami...

RECEIVED
CONSUMER SERVICES UNIT
02 JAN 2001 11:39

RECEIVED
CONSUMER SERVICES UNIT
02 JAN -7 AM 11:39

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14600,
Tallahassee, Florida 32317-4600

Has new
assessment?
Bran 10?

I. OFFICE INFORMATION
Name of Office: Anthony Hasan, M.D.
Miami, FL 33144, Dade County
Name of Physician or Licensee Reporting: Anthony Hasan, M.D.
License Information for Physician or Licensee Reporting:

7455 W. Flagler St.
Street Address
(305) 267 5434
Telephone
BH6367901
License Number

II. PATIENT INFORMATION

(754) 659-5124

[Redacted Patient Information]

Date of Office Visit: 12/18/01
Medical/Medicare

Parent Identification Number: _____
Diagnosis: lipodystrophy

Purpose of Office Visit: liposuction
ICD-9 Code for Diagnosis: 278.1

III. INCIDENT INFORMATION

12/21/01
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 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)

After the procedure, the patient was transferred to the recovery room in stable condition. Vital signs were within normal range. Prior to discharge, patient was placed in a sitting position which led to a vasovagal reaction. Family members were extremely concerned in spite of reassurances that the patient was fine. Patient stated [redacted] fat neck during [redacted] remaining time in the recovery room. [redacted] blood pressure (120/60), pulse (102), and R_s sat (102%) remained within normal range. Patient and family remained concerned, and asked to have the patient watched overnight in a hospital with a registered nurse. The patient was transferred to South Shore Hospital on an elective basis with normal vital signs and in stable condition. [redacted] was admitted for 23 hour observation, and discharged the following day in stable condition.

B) ICD-9-CM Codes

278.1 (liverectom)
 Surgical, diagnostic, or treatment
 procedure being performed at time of
 incident
 (ICD-9 Codes 86.0-86.9)

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 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.

Anthony Hasan M.D. (Bottle 367901) Surgeon 1/1/02
Richard Gonzalez CNA, MA (43430) Nurse Anesthetist 1/1/02
Robert Wren CNA (ARNA 916244) Nurse Anesthetist 1/1/02
María Del Carmen Alvarez RN, CAT (RN 281654) registered nurse 1/3/02
Gilda Ortiz surgical tech. / Cecilia Mayra surgical 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)

orthostatic hypotension / vasovagal reaction

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

Transfer to hospital for further observation and evaluation.

V.

[Signature] Bottle 367901
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

1/3/02
 DATE REPORT COMPLETED

17:00
 TIME REPORT COMPLETED

142



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

02 JAN - 7 PM 1:23
NA

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

I. OFFICE INFORMATION

Harris Dermatology
Name of office
Ft Myers 33407 Lee
City Zip Code County
Brian A. Harris, M.D.
Name of Physician or Licensee Reporting

12630 World Plaza Lane #70
Street Address
941-936-3344
Telephone
ME 0051092
License Number

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient Name
[Redacted]
Locating Information
Patient Identification Number
CONUSION - RT INFERIOR TIBIA
Diagnosis
FRACURE - RT TIBIA

[Redacted]
Age Gender Medical History
67-10-01
Date of Office Visit
FR FALLS -
Purpose of Office Visit
FR NOT DONE TODAY
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

12-10-01 2:35 PM
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)

PARETAKER STATES " [Redacted] WALKED INTO FRONT DOOR AREA AND FELL ONTO FLOOR IN THE OFFICE."

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 800-999.9)
---	--	---

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 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.

[Redacted]

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

[Redacted]

IV. ANALYSIS AND CORRECTIVE ACTION

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

*Pt has walker which tripped [Redacted] - caregiver states
Pt falls all the time.*

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

[Redacted]

V. *[Signature]* *ME0051092*
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
12-10-01 *2:40*
DATE REPORT COMPLETED TIME REPORT COMPLETED

I called
MD (Brian Harris)
143



Only report
to Governor

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
JAN 28 AM 11:41

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: Harris Dermatology
City: Ft. Myers Zip Code: FL 33907 County: Lee
Name of Physician or Licensee Reporting: Brian A. Harris, M.D.

Street Address: 12630 World Plaza Lane #7
Telephone: 941-936-3344
License Number: ME 0051092

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Name: [Redacted]
Locating Information: [Redacted]
Patient Identification Number: [Redacted]
Diagnosis: Basal Cell Carcinoma

Age: [Redacted] Sex: [Redacted] Ethnicity: [Redacted]
Date of Office Visit: 1/21/02
Purpose of Office Visit: SKIN Cancer Surgery
ICD-9 Code for Diagnosis: 173.3

III. INCIDENT INFORMATION

Incident Date and Time: 1/21/02 12:00

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 N/A

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

Patient was in exam chair when [Redacted] suddenly got cold chills. Told me [Redacted] had to go to the bathroom & was also feeling nauseous. Accompanied pt. to bathroom where [Redacted] began having diarrhea & vomiting. [Redacted] continued to experience cold sweats. The pt. told me this has happened previously when [Redacted] took Amoxicillin. [Redacted] called [Redacted] to inform him prior to taking [Redacted] drug that a.m. & the nurse told [Redacted] to take it a food & [Redacted] will be fine. [Redacted] told me that [Redacted] took it a 2 pieces of toast & a bowl of oatmeal. The pt. continued to have diarrhea & vomiting. with [Redacted] consent we called 911 for pt. to be taken to the hospital. This incident occurred approx. between noon & 1⁰⁰ p.m.

B) ICD-9-CM Codes

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

Dr. Alex [unclear]
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Ø
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	** 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.

Leslie Bishara - with patient in exam room + bathroom caring (Medical Assistant) for [redacted] while vomiting
Jennifer Johnson - Administrative Staff - called 911

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)

Mostly apparently a reaction to Amoxicillin

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

called 911

V. [Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME0051092
LICENSE NUMBER

1/25/02
DATE REPORT COMPLETED

9:45
TIME REPORT COMPLETED

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

RECEIVED
CONSUMER SERVICES UNIT
02 JAN 28 AM 11:48



Handwritten notes:
Board
Conty. NO
offices available
to Prof. Panel
AAAPPS
Florida
Jimmey
1/1/02
Jimmey
1/1/02

I. OFFICE INFORMATION
LEONARD SPILLERT, M.D. - *Coastal
Cosmetic
Center*
Name of office
JACKSONVILLE 32216 DUVAL
City Zip Code County
LEONARD SPILLERT
Name of Physician or Licensee Reporting

4083 SALISBURY ROAD
Street Address
904-332-6774
Telephone
ME 17473
License Number

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION
[Redacted]
Patient Name
[Redacted]
Age Gender Medicaid/Medicare
Locating Information [Redacted]
Patient Identification Number
LAX ANTERIOR ABDOMEN
Diagnosis

Date of Office Visit
CORRECTION ABDOM. LAXITY
Purpose of Office Visit
759.9
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION
JANUARY 15, 2002 (13:30)
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)

PATIENT UNDERGOING ABDOMINOPLASTY UNDER
GENERAL ANESTHESIA. FOLEY INSERTED AT
COMMENCEMENT OF PROCEDURE. AT
COMPLETION NOTED TO NOT BE DRAINING
— RECHECKED & REINSERTED — SEVERAL
CC'S URINE BUT CLOGGED 2 BLOOD CLOTS,
IRRIGATION FAILED TO OPEN BLOCKAGE — PT.
6 URINARY RETENTION. TRANSFERRED TO
BAPTIST MEDICAL FOR UROLOGICAL EVALUATION.

B) ICD-9-CM Codes

759.9

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

786.20

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

NONE

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	** 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.

LEONARD SPILLERT, MD; ME 0017473; SURGEON
JAMES ROBERTS, CRNA; ANESTHESIA PROVIDER
LICENSE NO. ARNP 1590592

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)

POSSIBLE URETHRAL STRICTURE CAUSING BLEEDING
+ BLOCAGE FOLEY DRAINAGE. PATIENT
TRANSFERRED TO BAPTIST ER for UROLOGY CONSULT

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

PATIENT WAS SUCCESSFULLY CATHETERIZED
AT BAPTIST HOSPITAL EMERGENCY DEPT. AND
DISCHARGED HOME AT ABOUT 17:30 on 1/15/08

V. Leonard Spillert ME 0017474
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
1/29/08 10:15 AM
DATE REPORT COMPLETED TIME REPORT COMPLETED