

NOT Relevant

197



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
02 AUG 27 AM 1:38

I. OFFICE INFORMATION

Southeastern Urological Center, P.A.
Name of office

Tallahassee 32308 Leon
City Zip Code County

W. Paul Sawyer, M.D.
Name of Physician or Licensee Reporting

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

2000 Centre Pointe Blvd
Street Address

850-201-0408
Telephone

ME27104
License Number & office registration number, if applicable

II. PATIENT INFORMATION



8-12-02 Date of Office Visit

Follow-up visit Purpose of Office Visit

urinary incontinence
Diagnosis

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

III. INCIDENT INFORMATION

8/12/02 2:00 p.m.
Incident Date and Time

Location of Incident:
 Operating Rm
 Recovery Rm
 Other Doc. 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)

while in exam room, patient began to complain of chest pain. Staff started oxygen and gave patient nitroglycerin tablets. Started IV and called Ems. Patient transported to Tallahassee Memorial for further evaluation and treatment by internal medicine / cardiology.

B) ICD-9-CM Codes

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

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

N/A
Resulting injury (ICD-9 Codes 800-999.9)

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

(Use additional sheets as necessary for complete response)

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>Jallahassee Memorial</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
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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.

<u>Angie Jougne, RN</u>	<u>Staff nurse</u>	<u>3066282</u>
<u>Jeany Spear, RN</u>	<u>Clinical Services Director</u>	<u>91591-2</u>
<u>W. Paul Sawyer, M.D.</u>	<u>Physician</u>	<u>ME 27104</u>
<u>Kay Novello, RN</u>	<u>Risk manager</u>	<u>5500848</u>

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)

Symptoms unrelated to urological diagnosis.

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

Patient evaluated + appropriately transferred to hospital for further evaluation + treatment.

V. Kay Novello, RN for W. Paul Sawyer, M.D.
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
8/13/02 10:00 a.m.
 DATE REPORT COMPLETED TIME REPORT COMPLETED

198

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
02 AUG 28 AM 8:04

Chemo Reaction
NOT RELEVANT

I. OFFICE INFORMATION

Space Coast Medical Associates
Name of office

Titusville FL 32780 BREVARD
City Zip Code County

Richard Levine, MD
Name of Physician or Licensee Reporting

Locating Information for Physician or Licensee Reporting

850 Century Medical Drive
Street Address

321-268-4200
Telephone

ME0040927
License Number

II. PATIENT INFORMATION

[Redacted]
Patient Name

Locating Information

Navy Hodgkin's Lymphoma
Patient Identification Number
Diagnosis

08-16-02 Gender: Male Medicaid/Medicare

Date of Office Visit

chemotherapy
Purpose of Office Visit

202.08
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

8-16-02 10:45 am
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)

Rituxan 600mg / 500cc NS ordered for infusion. Patient has had rituxan before
5 incident. Infusion initiated at 1040 - at 1045 pt reported severe low
back pain - face flushed - BP 164/90 P88. Rituxan infusion stopped -
normal saline infused - placed on O2 4L/min - patient examined by MD - VS
monitored q 5 mins - pt re-examined by MD and order received for
transport to ER at 11⁵⁰ AM.

(36)

(37)

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
J9310 - Rituxan / 96410 - Administration of chemotherapy	E933.1 Primary systemic agent - antineoplastic drug	963.1 Poisoning by primary systemic agent - antineoplastic.

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

N/A

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a 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
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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. Care of patient.

Terry McFarland RN 9180929 850 Century Medical Drive Titusville FL 32796 phone 321-268-4200	Nora Fetherman RN 1828792 850 Century Medical Drive Titusville FL 32796 phone 321-268-4200
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F) List witnesses, including license numbers if licensed, and locating information if not listed above

AS ABOVE

IV. ANALYSIS AND CORRECTIVE ACTION

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

pt had adverse reaction to Rituxan -
pt sent to Parrish Medical Center

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

pt was released from Parrish Medical Center
in satisfactory condition after evaluation in ER

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

DATE REPORT COMPLETED

TIME REPORT COMPLETED

LICENSE NUMBER

199



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 SEP 24 AM 7:58



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

Chemo Resumes

Not relevant

I. OFFICE INFORMATION

Name of office Florida Community Cancer Center

City Brooksville Zip Code 34601 County Hernando

Name of Physician or Licensee Reporting Sharon Robitille MD

Patient's address for Physician or Licensee Reporting 129 Oak Lane Dr Spring Hill FL 34608

Street Address 11307 Cortez Blvd

Telephone 352-596-1926

License Number & office registration number, if applicable PA 3176322

II. PATIENT INFORMATION



Age 9-11-02 Gender Female Medicaid Medicare

Diagnosis lung cancer

Date of Office Visit 9-11-02

Purpose of Office Visit chemotherapy

ICD-9 Code for description of incident H22.3 Resp Arrest 518.812

III. INCIDENT INFORMATION

Incident Date and Time 9-11-02 12:15 pm

Location of Incident:
 Operating Rm Recovery Rm
 Other chemo room

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

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

pt receiving chemotherapy - Gemzar infused 3 difficulty - Carboplatin
p 5 min = 17.4 mg = pt c/o dizziness and SOB - respiratory arrested
pt placed on floor - airway obtained and pt abt ambu bagged
x 5 min - wake up when EMS arrived - transported to Oak Hill
Hospital via EMS where she was admitted.

B) ICD-9-CM Codes

V58.1
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

518.81
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

unknown
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>admitted</u> Name of facility to which patient was transferred <u>Oak Hill 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.

Sharon Robitille RN RN 3176322 - treating nurse
Barbara Care RN error

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

Barbara Care RN 601502

IV. ANALYSIS AND CORRECTIVE ACTION

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

Allergic reaction to carboplatin - respiratory arrest

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

carboplatin D/d - pt airway maintained - transferred to Oak Hill Hospital via EMS

V. Sharon Robitille RN RN 3176322
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

9-11-02 1300
DATE REPORT COMPLETED TIME REPORT COMPLETED

200



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 OCT - 1 AM 7:50

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

Chemo reaction
Not NELE/AMT

I. OFFICE INFORMATION

Name of office: Florida Community Cancer Center
City: Brooksville Zip Code: 34613 County: Hernando
Name of Physician or Licensee Reporting: Gail D. Equatuk
Patient's address for Physician or Licensee Reporting: _____

Street Address: 11307 Carter Blvd
Telephone: (352) 596-1926
License Number & office registration number, if applicable: 915242

II. PATIENT INFORMATION

Diagnosis: Metastatic Bronchoalveolar carcinoma
Date of Office Visit: 09/06/02
Purpose of Office Visit: chemotherapy treatment
ICD-9 Code for description of incident: _____
Level of Surgery (II) or (III): _____

III. INCIDENT INFORMATION

Incident Date and Time: 09/06/02 125m

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. slept throughout treatment, productive cough - loose
whitish sputum. Pt unable to be aroused. Ineffective breathing
pattern. Mucoid membranes of mouth cyanotic. O2 via
N/A applied. Suctioned orally. EMS called. Pt transferred
via stretcher to ambulance to Oak Hill Hospital. Pt's resp. remain
slow & shallow but pt responding verbally and following
commands at time of transfer.

B) ICD-9-CM Codes

158.1/162.8
Surgical, diagnostic or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

162.8/786.05
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

Unknown
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>admitted</u> Name of facility to which patient was transferred <u>Oak Hill 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.

Gail D. Egnatuk 915242
John Brodtman 2729692
Sharon Robitille 3176372

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. medical condition and ineffective breathing pattern

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

O2 via n/c, Suctioned, transfer to Hospital

V.

Gail D. Egnatuk
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
7-6-02
DATE REPORT COMPLETED

915242
LICENSE NUMBER
4:15 pm
TIME REPORT COMPLETED

? board cert?
? hosp cred?
? accredited?

09/17/04 05:58 FAX 9225038
CONSUMER SERVICES UNIT

02 OCT -1 AM 7:50



201

BD OF MED



02

STATE OF FLORIDA
Jeb Bush, Governor

YES Board certified
BY - GA gastroenterologist
- NO - Accredited
Hospa priv only
@ Pembroke

perforation
sigmoid colon

Not
Accredited

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
GASTROINTESTINAL DIAGNOSTIC CENTERS
Name of office
Pembroke Pines 33024 Broward
City Zip Code County
Howard A. Rubenstein, MD
Name of Physician or Licensee Reporting

2245 N. UNIVERSITY DRIVE
Street Address
(954) 963-0888
Telephone
ME 56649 - Reg # 175
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



MARCH 22, 2002
Date of Office Visit
T. UNDERGO Colonoscopy
Purpose of Office Visit
569.83
ICD-9 Code for description of incident
II
Level of Surgery (II) or (III)

Diagnosis
Name positive (occult) stool & constipation

III. INCIDENT INFORMATION

MARCH 22, 2002 9:15 AM
Incident Date and Time

Location of Incident:
 Operating Rm
 Other Endoscopy Room
 Recovery Rm

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

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

The patient after obtaining informed consent was given supplemental oxygen (3L via nasal cannula), sedated with 10mg Valium IV & 1mg Midazolam IV (given individual doses) and placed in the left lateral decubitus position. The external & digital exam were normal. Next the video colonoscopy was initiated. At 40cm of the left colon a 5-6mm sessile polyp was removed by snare polypectomy technique. A 2mm larger polyp 1.0cm above at 50cm (not removed). The colonoscope then advanced to midtransverse colon. At this point there was noted to be blood oozing out the rectum. The scope was then withdrawn & the underlying mucosa was examined. There appeared to be a perforation at the level of the sigmoid colon. At this point 911 was called & emergency personnel were on their way. The patient was hemodynamically stable (BP 100/60, HR 55, RR 14 O₂ saturation 96%).
As well as the Emergency Room Physician at Memorial Hospital Pembroke to inform him of the situation.

III

A. Describe circumstances of the incident (narrative continued)

all the while the patient continued to be monitored.
Arrangements were made for a colorectal surgeon to see the patient at the emergency room. Paramedics arrived and the patient was transported to Memorial Hospital Brooke, which is just two miles from our office. I contacted the patient's son in [redacted] informing him of the situation and that his [redacted] was being transported to the hospital.

* The polyp of 50mm of the left colon was planned to be removed at the conclusion of the colonoscopy, because of its size. Owing to the perforation it could not be removed at this time. Also, the polyp initially removed was to be retrieved at the conclusion of the procedure.

Howard A. Rubenstein

B) ICD-9-CM Codes

45378	45378	569.83
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) OLYMPUS CF 100L VIDEO COLONOSCOPE

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 SURGICAL REPAIR Name of facility to which patient was transferred MEMORIAL HOSPITAL PEMBROKE	<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.

HOWARD A. RUBENSTEIN, MD	FL LICENSE ME 0056649	2245 N. UNIVERSITY DR.	PIMMORRE PING, FL 33024
NORA KELLY, RN	FL LICENSE 74588-2	" "	SAME " " " "
SARI DAUNPORT	GI. TECH	" "	SAME " " " "

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)

TEAR IN RECTUM FROM COLONOSCOPE. THIS LIKELY OCCURRED FROM TORQUING THE COLONOSCOPE THE TEAR WAS NOT AT THE LEVEL OF THE POLYPECTOMY SITE (IT IS NOT UNUSUAL TO TORQUE THE COLONOSCOPE IN PERFORMING COLONOSCOPY)

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

THE PATIENT WAS SENT TO MEMORIAL PEMBROKE HOSPITAL. HERE UNDERWENT SURGICAL REPAIR OF THE TEAR BY PRIMARY ANASTOMOSIS (NOT REQUIRING COLOSTOMY) BY THE COLORECTAL SURGEON.

V.

Howard A. Rubenstein ME 0056649
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
 09-20-02 2:00 PM.
 DATE REPORT COMPLETED TIME REPORT COMPLETED

202



Conway
recovery



N/A

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 OCT -7 AM 7:49

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 Watson Clinic
City Lakeland Zip Code 33801 County Polk
Name of Physician or Licensee Reporting Dr. Guttuso RN
same
Locating Information for Physician or Licensee Reporting

Street Address 11000 Lakeland Hills Blvd
Telephone 813-680-7000
License Number 1751902

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]
Date of Office Visit 9.18.02
Purpose of Office Visit
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

Incident Date and Time 9/18/02

Location of Incident:
 Operating Rm Recovery Rm
 Other CT scan

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

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

Pt arrived to CT scan pt injected 125cc Optiva 350
8:05 - Pt. states [redacted] felt warm + became unresponsive
Blue team called immediately after Code 99 called.
Code Team + Dr. Eckelburg + Dr. Guttuso responded
CPR in progress through out code - Meds 5ml Medrol
Tagamet, Benedryl + .50 mg Epi given via IV
Monitor applied 8:05 on pt until D/C then on
EMS monitor - EMS intubated + shocked pt upon
arrival Rhythm 147 No palpable pulses.

B) ICD-9-CM Codes

CAT SCAN Follow up
given

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

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

Resulting injury
(ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

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

Pat Cardin ARNP 306902 RN 1699652 Brenda Entekin ME 81774 Dr. Giustuso
 Karla Glottelty 2600102 Ronda Riley RT/ARRT 185748 General Rad. 21212
 Bunny Grappuso 1751902 Melissa Kelly
 Appie Howell RN 1467812 Dr. Eckelberg ME 81774 ME 16987
 Lt Tech General Rad. 47653

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 opt ray injection successfully
 coded to rhythm - pulse ST tube in place
 at ambu - O2

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

V. [Signature]
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
9/18/02
 DATE REPORT COMPLETED

ME 16937
 LICENSE NUMBER

9:50 a
 TIME REPORT COMPLETED

203

1. insert of catheter - SOB -> concluded
to ec. No incident occurred



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
02 OCT - 9 AM 7:57

Not relevant

I. OFFICE INFORMATION

Southeastern Urological Center, P.A.
Name of office

2000 Centre Pointe Blvd
Street Address

Tallahassee 32308 Leon
City Zip Code County

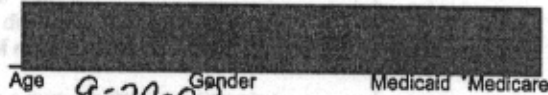
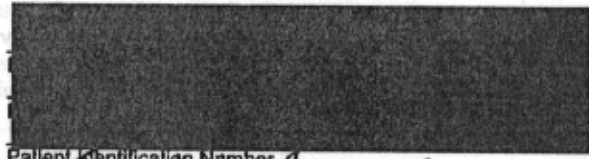
850-201-0468
Telephone

Joseph X. Camps, M.D.
Name of Physician or Licensee Reporting

ME57214
License Number & office registration number, if applicable

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

II. PATIENT INFORMATION



Prostate Cancer
Patient Identification Number
Diagnosis

9-27-02 Age Gender Medicaid/Medicare
Date of Office Visit
Irrigation of urinary catheter
Purpose of Office Visit

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

III. INCIDENT INFORMATION

9-27-02 9:45 a.m.
Incident Date and Time

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

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

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

Patient came to office for irrigation of urinary catheter. Has pacemaker and AICD. Became increasingly short of breath while in office. Office staff notified patient's cardiologist and called EMS. Patient transferred to Tmt E.R. for further evaluation and treatment by cardiologist.

02 OCT -9 AM 7:52
PHYSICIAN SERVICES UNIT

B) ICD-9-CM Codes

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

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

D) Outcome of Incident (Please check)

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

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

<u>Byron Blasko, ARNP</u>	<u>ARNP 1554842</u>
<u>Mary-Jane Ford, RN</u>	<u>8070262</u>
<u>Joseph L. Camps, M.D.</u>	<u>ME 57214</u>

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 had known cardiac condition. Symptoms unrelated to patient's urological diagnosis

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)
Patient appropriately transferred to hospital for further evaluation in E.R.

v. Haymondello ANRM for J.L. Camps, M.D. 5500848/ME 56136
 SIGNATURE OF PHYSICIAN/LICENSÉE SUBMITTING REPORT LICENSE NUMBER
10-1-02 11:15 a.m.
 DATE REPORT COMPLETED TIME REPORT COMPLETED

204

Chemotherapy



2013

STATE OF FLORIDA
Jon Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

NOT RELEVANT

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

RECEIVED
CONSUMER SERVICES UNIT
02 OCT 16 AM 7:48

I. OFFICE INFORMATION

Northwest Oncology ~~9100~~ ~~Wests~~
Name of office
Coral Springs 33065 Blvd
City Zip Code County
Dr Steven Weiss
Name of Physician or Licensee Reporting

8170 Royal Palm Blvd
Street Address
(954) 755-1904
Telephone
ME057847
License Number

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

Locating Information

Patient Identification Number

Diagnosis

Age Gender Medicaid Medicare
9-27-02
Date of Office Visit
Chemotherapy tx
Purpose of Office Visit
183.0
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

9-27-02 11 AM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other Outpt Office

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

NIA

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

Pt "re-challenged" with Wk # 2 of Carboplatin (Pt known to have sensitivity to this drug in past but able to tolerate previous doses of Steroids). Decadron 10mg IV + Solu-Cortef 100mg IV + Ciprofloxacin 100mg IV pre-carbo given. (120mg of Carboplatin in 200cc NS) + ran 11cc (20mg) when pt became red faced, eyes bloodshot, restless, ↑↑ diaphoretic, Bp ↓ to 80 palpable, Paracetamol stopped, IV NS wide open, Trendelenburg, Solu-Cortef 50mg NP + Benadryl 20mg NP for severe "itching". Fingers blue, intermittent tremors/rigors. Coughing but lungs clear. Bp recovered, O2 sat dry. Still red faced, tongue "thick". Fingers still blue... 911 → CS MC →
Approx: 1230/p → discharged approx 430/pm

B) ICD-9-CM Codes

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

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

Resulting injury (ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

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

Ana Marie Singh TN29698 - Lab Person
 Mary Fifeild RN735212 - Chemo RN OCA
 Dr Steven Weiss MD ME057847

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

MARY FIFEILD RN735212 - Chemo Nurse

IV. ANALYSIS AND CORRECTIVE ACTION

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

Sensitivity / allergic Reaction to Carboplatin -> then became Extrapyramidal due to Steroids + Benadryl.

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

Change Chemo drug from Carboplatin to another drug

V. Steven Weiss SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER 57847

DATE REPORT COMPLETED 9/30

TIME REPORT COMPLETED 3 PM

205



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
02 OCT 30 AM 7:32

1 row
infusion
low hemoglobin

NOT RELEVANT

I. OFFICE INFORMATION

Name of office FCCC ISCC
City SCC Zip Code 33573 County Hills
Name of Physician or Licensee Reporting Dr. George Dermoker
Locating Information for Physician or Licensee Reporting

Street Address 11031 Under Creek Dr.
Telephone 813-633-2733
License Number ME 0002547

II. PATIENT INFORMATION

Patient Name [Redacted]
Age 10-9-02 Gender [Redacted] Medicaid/Medicare [Redacted]
Date of Office Visit 10-9-02
Purpose of Office Visit IRM infusion
Patient Identification Number [Redacted]
Diagnosis iron def. anemia w/ renal failure
ICD-9 Code for Diagnosis 280.9 w/ 58.5.0

III. INCIDENT INFORMATION

Incident Date and Time 10-9-02 @ 12:20pm

Location of Incident:
 Operating Rm Recovery Rm
 Other facility

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

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

Pt presented for tx to % severe weakness & SOB. IV started & NS infusing. Labs drawn (Hgb 5.4) Pt restless. Benadryl 25mg IV PB given. Iron infusion started. Pt continued to restlessness. Halfway into iron infusion restlessness T & D (no pain) Iron stopped NS infusing ARNP & Dr. present Benadryl 25mg IVP & Decadron 10mg IVP given. Emergency Squad called to transport pt to SBH J 98' P 58' B/P 130/76
Pt stated [Redacted] had been restless x 2 wks.

10/27/02

B) ICD-9-CM Codes

280.9
Surgical, diagnostic, or treatment procedure being performed at time of incident
(ICD-9 Codes 01-99.9)

~~280.9~~ 786.09
Accident, event, circumstances, or specific agent that caused the injury or event.
(ICD-9 E-Codes)

786.09
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)

NIA

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.

Beth Caldwell, RN License # 1915292
Katharina Low, ARNP License # 3396982
George Dermakar, MD License # ME62547

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

NIA

IV. ANALYSIS AND CORRECTIVE ACTION

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

Due to hgb level not non infusion - transported for emergent blood transfusions and monitoring per hospital staff.

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

None needed.

Katharina Low

V. Katharina Low ARNP
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ARNP 3396982 FL
LICENSE NUMBER

10/9/02
DATE REPORT COMPLETED

1510
TIME REPORT COMPLETED

GMW 10/2/02

ST procedure
ST elevation
after hand wash

206



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 NOV -4 AM 7:36

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 33804 Polk
City Zip Code County
Karla Gotsfelty
Name of Physician or Licensee Reporting
Watson Clinic
Locating Information for Physician or Licensee Reporting

1600 Lakeland Hills Blvd.
Street Address
863 680-7000
Telephone
262 0102
License Number

II. PATIENT INFORMATION

[Redacted]
Patient Identification Number
CHD MI
Diagnosis

[Redacted]
Age 10-24-02 Gender Medicaid Medicare
Date of Office Visit
STRESS test, nuclear
Purpose of Office Visit
414.00
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

10-24-02 2:55pm
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other Nuclear Med

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)

Completed treadmill. During recovery phase
of stress test physician noted ST elevation
and Ntg drip being at 5mcg IV. D222 NC initiated.
EmS called. To cath lab via EMS at LPMC.

B) ICD-9-CM Codes

78465
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

4139
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

4139
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
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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.

Frank Moseley Moseley - 59420 - Temp. license #
DR. Helena Mahias - ME0047141

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

Cindy O'steen, # 1734782 Scott Moor
Karla Giotfelty 2620102

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

To hospital via ambulance

V. Karla F Giotfelty 2620102
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
10-24-02 3:30pm
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

*no process
Sizemore
Chow*
CONSUMER SERVICES
02 NOV -5 AM
NOT RELEVANT

207

I. OFFICE INFORMATION

Cancer Centers of Florida
Name of office
Orlando 32806 Orange
City Zip Code County
Rachel Burg
Name of Physician or Licensee Reporting
52 W Gore St
Locating Information for Physician or Licensee Reporting

52 W Gore St
Street Address
4074268484
Telephone
License Number

II. PATIENT INFORMATION

[Redacted]
Locating Information
Patient Identification Number
metastatic Breast Cancer
Diagnosis

[Redacted]
Age Gender Medicaid Medicare
10-22-02
Date of Office Visit
Follow up
Purpose of Office Visit
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

10-22-02 1050 AM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other office

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

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

Pt. brought to office by [Redacted] for follow up office visit.
Pt. entered chemotherapy suite by wheel chair @ 1054 having
apparent active seizure accompanied by [Redacted] and
Dr. Barman. 911 called - pt. unresponsive, pulse weak,
unable to obtain s/p - Mediquet accessed by tube 20g 1" and 50 cc NS
infused side open - O2 on @ 2L - emergency transport here @
1050A - pt. slightly responsive - pulse 80, regular - report given to EMT
and pt. transported to hospital

B) ICD-9-CM Codes

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

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

N/A
Resulting injury (ICD-9 Codes 800-999.9)

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

O2, NS 500cc

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.

Barry Berman MD
Robin Clark RN
Rachel Burg RN
Laurie Amadio ARNP

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

[Redacted]

IV. ANALYSIS AND CORRECTIVE ACTION

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

N/A

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

N/A

V.

Robin Clark RN
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
10/22/00 1400
 DATE REPORT COMPLETED TIME REPORT COMPLETED

*Pulmonary
hemorrhage during
heart catheterization
no response*

209

208

[Redacted]

*Yes, only Heart Cath
Board cert, yes American
Board*

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
NOV 14 AM 7:50

*Hosp pur
AGH
Hosp*

I. OFFICE INFORMATION

Name of office: Cardiology Associates of Gainesville Street Address: 4645 NW 8th AVE.
City: Gainesville Zip Code: 32605 County: Alachua Telephone: 352-377-1212
Name of Physician or Licensee Reporting: Steve Roark License Number: ME 38483
Locating information for Physician or Licensee Reporting: 352-377-1212 (Bryan Baldwin RN 2508252)

*Cath lab
account to
State of
medical
report
should not
have been
filed*

II. PATIENT INFORMATION

Patient Name: [Redacted] Age: [Redacted] Gender: [Redacted] Medicaid: [Redacted] Medicare: [Redacted]
Locating information: [Redacted] Date of Office Visit: 10-16-07
Patient Identification Number: [Redacted] Purpose of Office Visit: Right and Left Heart Catheterization
Diagnosis: Abnormal Cardiovascular Study ICD-9 Code for Diagnosis: 794.30

III. INCIDENT INFORMATION

Incident Date and Time: 10-15-02 1110 Location of Incident:
 Operating Rm Recovery Rm
 Other Cath Lab

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

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

During a Right heart Catheterization while measuring
Pulmonary arterial pressure, pt. was noted with hemop-
tysis which increased in amount with a decrease in
oxygen saturation. A left heart catheterization was also
being done at the same time without any adverse events
related to that procedure.

B) ICD-9-CM Codes

93526	417.8, 416.0	786.3, 518.82
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)
#7 French Swan Ganz Double lumen monitoring catheter, #7 French pinnacle sheath

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 <p style="font-size: small;">** if it resulted in</p> <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer of the patient
---	--

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

Steven F. Roark ME # 38483, Bryan D. Baldwin RN 2508252
 Denise Mangiardo RCIS, Christen Imler CPT, Steven Roark MD -
 Cathing physician, Bryan Baldwin - Case recorder, Denise Mangiardo
 RCIS - Circulator, Christen Imler CPT - Scrub Tech.

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

Kim Giberti RN 2750592

IV. ANALYSIS AND CORRECTIVE ACTION

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

DUE TO PULMONARY HYPERTENSION, A WIRE WAS
UTILIZED TO MANIPULATE THE SWAN-GANZ CATHETER
INTO THE PA. PRESUMABLY THE WIRE PERFORATED
A SMALL PULMONARY ARTERIOLE.

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

Blood Suctioned, Ems activated, Catheters pulled back, Procedure Stopped. Pt. placed
on 100% O2 (Non rebreather mask) then changed to Bag mask Ventilation. Pt. responded
well to oxygen therapy and suctioning of mouth with an increase in O2 Saturation.
Pt. transferred to Shands at Alachua General Hospital via Ems for observation.
Pt. followed throughout by Roach MD during hospitalization until discharge home.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 38483
LICENSE NUMBER

11/2/02
DATE REPORT COMPLETED

16⁴⁵
TIME REPORT COMPLETED

11/2/02 - Pt seen in clinic today in F/U -
doing well - no sequelae from
pulmonary hemorrhage.

(Dugan J. Bullock RN 2508252)

This report was prepared by myself and
Steven Roach MD.