

Chemo Rx

~~145~~ 145



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 FEB -5 AM 11:48

**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
Cindy O'Steen
Name of Physician or Licensee Reporting
Same as above
Locating Information for Physician or Licensee Reporting

11600 Lakeland Hills Blvd
Street Address
813-680-7000
Telephone

License Number

616 2480
AAHC

II. PATIENT INFORMATION

[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
Small Cancer of Lung/Liver
Diagnosis

[Redacted]
[Redacted]
2-1-02 Gender Medical/Medicare
Date of Office Visit
Chemo
Purpose of Office Visit
112.9 197.7
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

2-1-02 9⁴⁰ 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)

Began Taxol treatment IV. Pt complained of severe weakness. Pt immediately became unresponsive. Blue team called. Pt found upon arrival apneic & pulseless. Pt placed on floor & CPR initiated x 1 min. Monitor showing sinus tachycardia 150 & ST depression of 3mm. O2 @ 100% nonrebreather SaO2 91% BP 240/110 Unresponsive. DSW KVO. 94% ACLS ambulance called Resp 20 BP 226/100 P-117 SaO2 94% IV-NS KVO 98% Ambulance arrived pt moving, appropriately responding to commands. BP 210/102 P-115 SaO2 96%

B) ICD-9-CM Codes

19265 96410 19265 427.5 799.1
 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-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)

IV Pump, Diagnostics Post Arrest Cardiac Monitor, Ambu Pulse Oximetry

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.

Dr. Ruben Saez ME 74565 Buzz Hall (William) RN 2515750 Equip.
Dr. Eric Lipson ME 0056759 - Airway Heather O'Connor RN 187822 - Book
Dr. Paul Butkus ME 81724 - Monitoring Nepair Howell BP's
Dr. Richard Rutherford ME 0030405 Monitor Chris Clark RN 2001692 Equip.
Cindy O'Steen RN 1734782 Chest Compression
F) List witnesses, including license numbers if licensed, and locating information if not listed above
Dawn Polk RN 1530840

IV. ANALYSIS AND CORRECTIVE ACTION

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

Unknown - This was the patient's first treatment with Taxol. Recently diagnosed with lung cancer. This may have been a reaction of some sort to the Taxol but cannot rule out other causes.

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

Uncertain of need for specific corrective action as response to treatment could not have been anticipated.

V.

Cindy O'Steen RN 1734782
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
2-1-02 1045
 DATE REPORT COMPLETED TIME REPORT COMPLETED

Chemo MF



146

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 FEB 11 AM 11:54

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

SL1A

I. OFFICE INFORMATION

NAME OF OFFICE
JEREMY R. GEEFFEN, MD

STREET ADDRESS
981-37th PLACE

CITY
VERO BEACH ZIP CODE
32960 COUNTY
INDIAN RIVER

TELEPHONE
772-561-7709 ~~5800~~

NAME OF PHYSICIAN OR LICENSEE REPORTING
JEREMY R. GEEFFEN MD

LICENSE NUMBER
ME005497

LOCATING INFORMATION FOR PHYSICIAN OR LICENSEE REPORTING
VERO BEACH FL 32960

II. PATIENT INFORMATION



AGE
2/5/02 GENDER
MEDICAID MEDICARE

PATIENT IDENTIFICATION NUMBER
Prostate Ca chest pain

DATE OF OFFICE VISIT
Chemo therapy
PURPOSE OF OFFICE VISIT
185
ICD-9 CODE FOR DIAGNOSIS

III. INCIDENT INFORMATION

INCIDENT DATE AND TIME
2/5/02 1130

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 undergoing chemo therapy Temperature started dropping
within 80 minutes pt became flushed & 70 chest discomfort
increased by heaving & started on 10 94% 9p. 1/19/07 p. 76
skin warm & dry pulse 120. dennis SOB. 911 dispatched
along with D. Steffen made aware.

3

B) ICD-9-CM Codes

90000
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 <p>** If it resulted in</p> <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer of the patient
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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.

Chemo therapy nurse - Madelyn Van Name RN 1875752
Jeanine Smith RN 2199512

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

911 emergency dispatched

V.


SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 0051697
LICENSE NUMBER

2/5/02
DATE REPORT COMPLETED

11:50 am
TIME REPORT COMPLETED

Chew 14



147

STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
FEB 11 AM 11:45

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

I. OFFICE INFORMATION

ECCTC Brandon
Name of office

401 Vanderburg Drive
Street Address

Brandon 33511 Hillsborough
City Zip Code County

(813) 684-2339
Telephone

Maria T. Trice RN
Name of Physician or Licensee Reporting

RN3401622
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Identification Number

Age Gender Medicaid Medicare

Breast Ca 174.4
Diagnosis

1/29/02
Date of Office Visit

Follow-up
Purpose of Office Visit

Chest Pain SOB
ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1/29/02 9:30 AM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other Exam 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)

Patient came in for follow-up with Dr. Dermarker and port flush. After patient's exam & port flush patient attempted to leave when chest pain & SOB started. Pt was sat back down in exam room. Dr. Dermarker was called to exam room vitals were taken. Patient stable, EMS called to take patient to BRH ER.

B) ICD-9-CM Codes

329.160
Mediport Flush
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

413.1
Chest Pain, SOB
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

786.05
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)

N/A

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only <u>unknown</u> Name of facility to which patient was transferred <u>Brandon Reg. Hosp. ER</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.

Maria Trice R.N. witnessed pt grabbing at chest & having SOB. Patient was trying to leave exam room.

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

Pamela Pierce RN #RN1584472
Dr. Dermecker #ME162547

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)

Kept patient sitting upright, took vital signs, called EMS.

v.

<u>Maria Trice RN</u>	<u>RN3401622</u>
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
<u>1/29/02</u>	<u>10:30</u>
DATE REPORT COMPLETED	TIME REPORT COMPLETED

YMW 2-1-02
ELK



Anaphylaxis
CT
No Death
No Products

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 FEB 13 AM 11:38

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 West
Name of office
Gainesville 32607 Alachua
City Zip Code County
John S Shahan MD
Name of Physician or Licensee Reporting
1026 SW 2nd Ave, Gainesville 32601
Locating information for Physician or Licensee Reporting

4960 Newberry Rd., Ste. 280
Street Address
(352) 371-3336
Telephone
JR 3722900 MZ 39094
License Number

352-377-7120

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

Recurrent Lung Cancer
Diagnosis

2/11/02 Date of Office Visit
CT Scan of Chest, Abdomen, Pelvis Purpose of Office Visit
162.9 719.45 ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

2/11/02 - Approx 0915
Incident/Date and Time

Location of Incident:
 Operating Rm
 Recovery Rm
 Other CT scanner

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) 2/11/02
(use additional sheets as necessary for complete response)

at approximately 9:15 AM, I was called to see pt. for anxiety and pain. Patient had palpable pulse but was conscious. [Redacted] was pale & diaphoretic. I diagnosed a vasovagal reaction and gave O₂ by nasal cannula. [Redacted] had received 10cc of amnioxone 240 IV for CT contrast so I gave 10cc NaCl as that is possible. Subsequently pt began to close airway. I could not get a pulse. I decided [Redacted] was also having an anaphylactic reaction to IV contrast so I gave 5cc of IV 1% epinephrine and [Redacted] revived. We called 911; EMT's arrived within 10-15 mins. They stabilized [Redacted] with O₂ & IV saline; BProne to 60ayotaki. Pt never lost consciousness. Left for North Fla. Regional ED @ ~ 9:40 in relatively stable condition. No breathing problems. 10th hour MFA

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

^{142.9} ^{719.45}
74160, 71260

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

A 4645 E 947.8

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

977.8 995.0

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
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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.**

Krista Stevenson, RT (R)(CT)(MR) #33744
 Robert Hardin, RT (R)(MR) #2446 } assisted physician
 Dana Jordan, RT (R) #3174

*** 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)

Vasovagal reaction followed by anuplylacty check and angioneurotic edema. Pt. member lost consciousness

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

Pt responded to O2 by nasal cannula, IV saline, and 5cc of IV 1:10,000 epinephrine.

V. John S. Asham MD ME 39094
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

2/11/02
DATE REPORT COMPLETED

10:05 AM
TIME REPORT COMPLETED

GAINESVILLE RADIOLOGY GROUP



4960 Newberry Rd., Ste. 280 / Gainesville, Florida 32607 / (352) 371-3336 / FAX (352) 371-3372

Bruce K. Stechmiller, M.D.
720 SW Second Avenue, Ste. 160-N
Gainesville, FL 32601




The patient presented to our outpatient office for a CT scan of the chest, abdomen and pelvis in evaluation of recurrent lung cancer and pelvic/hip pain.

At approximately 9:15 a.m., I was called to see the patient for anxiety and pain. At that time the patient did not have an easily palpable radial pulse but was conscious. [REDACTED] was pale and diaphoretic. At that time I diagnosed a vasovagal reaction and gave [REDACTED] oxygen by nasal cannula. [REDACTED] had received 100 cc Omnipaque 240 intravenously for CT contrast so I also began an IV saline drip as fast as I could get it to run.

Subsequently the patient began to complain of shortness of breath and by physical examination appeared to be wheezing and also perhaps closing [REDACTED] airway. I did hear stridor through the stethoscope. At that time I could not palpate a radial pulse. The clinical diagnosis changed from vasovagal reaction to anaphylactic reaction to IV contrast. I gave [REDACTED] 5 cc of IV 1/10,000 epinephrine as well as a further infusion of saline intravenously. The patient began to revive quickly. During this time we called 911. Over the next 10 minutes the patient continued to stabilize although was still quite anxious. [REDACTED] never lost consciousness. The EMT personnel arrived within 10-15 minutes.

The EMT stabilized the patient with oxygen and IV saline. [REDACTED] blood pressure rose to 60 systolic. While they were here [REDACTED] never lost consciousness. Within a few minutes [REDACTED] left for North Florida Regional Medical Center, Emergency Department in relatively stable condition. [REDACTED] was having no breathing problems and was conscious. However, [REDACTED] blood pressure was still low.


John S. Shahan, M.D./krs
cd:

Agency for Health Care Administration
Consumer Services Unit
PO Box 14000
Tallahassee, FL 32317-4000

Mark F. Patlovich, M.D.

John S. Shahan, M.D.
Mary G. Alderman, M.D.

Preston R. Lotz, M.D.

J. Maxey Dell, Jr., M.D. (1907-1990)

DIPLOMATES, AMERICAN BOARD OF RADIOLOGY
ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY

PPATIENT PRESENTED FOR

**74160 CT ABDOMEN W/CONTRAST
71260 CT CHEST W/CONTRAST
A4645 OMNI CONTRAST MATERIAL**

PRESENTING DIAGNOSES

**162.9 MALIGNANT NEOPLASM, BRONCHUS AND LUNG UNSPECIFIED
719.45 PELVIC PAIN**

ADVERSE REACTION

**E947.8 ADVERSE EFFECT WITH THERAPEUTIC USE OF CONTRAST
 MATERIAL**

**995.0 ANAPHALACTIC SHOCK, NOS, OR DUE TO ADVERSE EFFECT OF
 CORRECT MEDICINAL SUBSTANCE PROPERLY ADMINISTERED**

**977.8 POISONING BY DRUGS, MEDICINAL AND BIOLOGICAL .
 SUBSTANCES, CONTRAST MEDIA USED FOR X-RAY
 PROCEDURES**

*Morphine overdose
no overdose
no procedure*

149

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT



PHYSICIAN OFFICE 02 FEB 13 AM 11:54
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

Tampa Pain Relief Center
Name of office

4703 N. Armenia Avenue
Street Address

Tampa 33603 Hillsborough
City Zip Code County

(813) 872-4492
Telephone

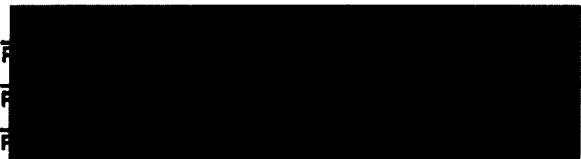
Winston C.V. Parris, M.D.
Name of Physician or Licensee Reporting

N/A
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

AAAH
Y

II. PATIENT INFORMATION



Date of Office Visit

Morphine Pump Refill
Purpose of Office Visit

Chronic Low Back Pain
Diagnosis

96530 (CPT)
ICD-9 Code for description of incident

N/A
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1/04/02
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 N/A
Was an autopsy performed? Yes No

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

Patient had office visit for refill of Morphine Pump. Received call a few hours later from Emergency Room Dept. at St Joseph Hospital. Allegedly, patient had collapsed at a store, 911 was called, patient taken to hospital. Emergency Room doctor administered Narcan and patient became more responsive. Admitted to hospital. Dr. Parris went to hospital and removed remaining Morphine in pump. Additional Narcan administered. Patient's vital signs remained stable and ready for discharge with no sequelae from incident

B) ICD-9-CM Codes

<u>96530 CPT (no comparable ICD9 code)</u>	<u>E850.2</u>	<u>965.09</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>St Joseph 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.

Michelle D. Hilton, RN 3382162
Winston C.V. Parris, M.D. ME0074042

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

IV. ANALYSIS AND CORRECTIVE ACTION

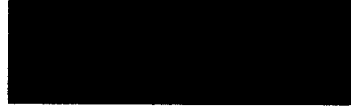
A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Probable that the bevel of needle was not fully inserted into the membrane of pump when the office nurse injected the Morphine into pump reservoir. Probable that some morphine leaked into muscle instead

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

Training of office nurses was enhanced to emphasize methods to check that medication is being completely inserted into the reservoir.

V. ME0074042
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
2/11/02 8:00AM
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 FEB 15 AM 11:59

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

Chono M
M.D.

I. OFFICE INFORMATION

Name of office Florida Community Cancer Center
City Brooksville FL Zip Code 34613 County Hernando
Name of Physician or Licensee Reporting Richard Caradonna MD

Street Address 11307 Cortez Blvd
Telephone 352 596 1926
License Number & office registration number, if applicable MECO49404

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Identification Number [Redacted]
Diagnosis Lung Cancer

Date of Office Visit 1-29-2
Purpose of Office Visit Chemotherapy
ICD-9 Code for description of Incident 995.2
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Incident Date and Time 1-29-2

Location of Incident:
 Operating Rm Recovery Rm
 Other Clinic

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

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

Primary IV of 250 NS started, premed Solumedrol 50mg IVP, cimetidine 300mg IVPB, benadryl 50mg, kytril 1mg given IVPB over 15 min. Taxol 80mg in 250cc NS hung @ 50cc/hr rate via pump. 15 min into Taxol clomausea - taxol turned off, skin turned warm + moist. BP 86/70. NS flow turned up + R Joseph RN notified. Denies chest pain or dyspnea. Alert + oriented. Said flat in chair. Solumedrol 50mg IVP given. 5 min later BP drop to 70/?, O2 put on 3l/nc still alert. No other cl. Sudden loss of consciousness, EMS called, 2nd dose Solumedrol 125mg IVP given, unable to insert airway, O2 via ambu bag, Dr Caradonna present, no pulse, CPR started, turned dusky P few min + CPR continuing. EMS arrived + took over CPR, gave emergency drugs + transported to hospital in full code by EMS squad.

B) ICD-9-CM Codes

458.1
Surgical, diagnostic, or treatment procedure being performed at time of incident
(ICD-9 Codes 01-99.9)

995.2 995.0
Accident, event, circumstances, or specific agent that caused the injury or event.
(ICD-9 E-Codes)

427.5
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>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 checked="" 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.

Dr. Carolonna - physician ME0049404, RN 2758482
Roberta Joseph RNOCN, Sharon Rob. Telli RN RN 3176322
Debbie Parker RNOCN ME68734, Michele Kaye RN RN 2628183, Shirley White RN RN 143219
John Brodman RN RN 2729642 - all involved in actual CPR code, Barbara
Cox RNOCN RN 60150-2 - initial chemo + treatment, called 911.

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)

was - reaction to Taxol

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

turned off Taxol at 1st sign of reaction, vitals monitored, sol medrol x2 given, O2 put on, CPR started + 911 notified, sent to hospital

V. Rebel R. Carolonna ME 0049404
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
2-1-1 4pm
 DATE REPORT COMPLETED TIME REPORT COMPLETED

QW
2-11-02

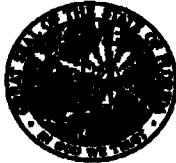
151
STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 FEB 15 AM 11:58

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

Chono M



I. OFFICE INFORMATION

Name of Office Fla Community Cancer Center

Street Address 11307 Cortez Boulevard

City Brooksville FL 34613 Hernando
City Zip Code County

Telephone Brooksville 352-596-1926

Name of Physician or Licensee Reporting Dr. Richard Caradonna

License Number & office registration number, if applicable MEC049404

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 2-4-2 Gender Medical/Medicare

Patient Identification Number
Diagnosis lung cancer 162.5

Date of Office Visit
Purpose of Office Visit Chemotherapy treatment
ICD-9 Code for description of incident 495.2 V58.1 995.2
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Incident Date and Time 2-4-2 10:00 AM

Location of incident: Operating Rm Recovery Rm
 Other Clinic

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

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

History of vomiting & cisplatin in past treatments. ^{10¹²} During cisplatin Rx started vomiting. Compazine 5mg im given & some nausea relief ^{10¹²} 10 min. At 10:20 AM clo pins + needles in face + arms. Cisplatin turned off. Skin warm + dry. Penis dyspnea or angina BP 100/50 P 98. Skin warm + dry E Morgan ARNP notified. About 10:25 eyes rolled back + became unresponsive. 911 called. Resp + pulse present. moved to hall - became responsive within 45 sec. Alert when responded. O₂ via mask. Skin warm + dry. BP 80/? palpated. 10:30 AM EMS transported to Oak Hill via EMS. Dr. Caradonna present during time in hall. HOSPITAL observation.

B) ICD-9-CM Codes

V58.1	995.2 39060	780.09
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 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>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
---	---

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

BARBARA CARR (NOC) RN 60150-2, Dr. Caradonna, ME 0049404, Elizabeth Morgan RNP 1938022
Roberta Joseph RN OLN RN 2758 482, John Brodtman RN RN 272 9692, Sharon
Robitelle RN RN 3176222, Michele Eger RN RN 260 29182
3 Care - chemo + 911 episode, rest of people 911 episode.

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

reaction to cisplatin

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

stopped cisplatin, O2, 911 called, sent to hospital for assess

V. Dr. R. Caradonna ME 0049404
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
2-4-2 2-5-2 4pm
 DATE REPORT COMPLETED TIME REPORT COMPLETED

MW 02-11-02

no. Macadine
Cardiac echo
fol. fax. 72003
C.H.F.



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT

02 FEB 18 AM 11:39

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: 33805 County: Polk
Name of Physician or Licensee Reporting: Heather O'Connor RN, BSN, MPH
Locating Information for Physician or Licensee Reporting: Clinical Services

Street Address: 1600 Lakeland Hills Blvd
Telephone: 680-7000
License Number: 1187572

II. PATIENT INFORMATION

Pat: [Redacted]
Loc: [Redacted]
Patient Identification Number: [Redacted]
Diagnosis: Cardiac Dyspnea

Date of Office Visit: 2/5/02
Purpose of Office Visit: Pulmonary Function
ICD-9 Code for Diagnosis: [Redacted]

III. INCIDENT INFORMATION

Incident Date and Time: 2/5/02. 4:12/PM.

Location of Incident:
 Operating Rm
 Other ER/CC Dept.
 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)

4:12 PM PT @ clinic for cardiac echo } Pulmonary Function testy for diagnosis
of shortness of breath - started phase I of PFT. Developed increased
dyspnea - RR 16, P 60, BP 108/58 - As patient changed position,
T resp distress - PT had diminished breath sound @ 2/3 -
Beltousee basilar rhonchi } rules -

On multipee maneuvers -
4:17 PM PT @ ER thursome ↓ pressure of 80/51 - T SOB, T RR to 18. Dr Bazzy based @ patient
4:25 PM BP 108/51 P 68 R-15 contras SOB but stable - Away returned of Dept to Bazzy
5:00 PM PT to urgent care - Dr Bazzy (OHN) returned base. BP 70/62 P 91 R-10

Off set 9:10 - Dr Muresilvered - chest x ray done -
58 - PT to be admitted to LEMC OR C.H.F.
1 of 2 pages

B) ICD-9-CM Codes

428.1
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

Unloading PR → 78596
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

428.1
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)

On, On Saccular cardiac monitor, BP cuff, stethoscope

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.

Heather O'Connor RN 1187572 } Watson Clinic
Buzz Hall 2515752 RN } 1000 Lakeland Hills Blvd

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

GPT Tech → Mary Smeek MA.

IV. ANALYSIS AND CORRECTIVE ACTION

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

PT. was adequately evaluated before JED by staff
was deteriorated due to symptoms
PT. admit by ambulance to LRMC - 96 CHF.

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

I don't think there is a way to PREVENT this type of outcome
was seen by DR. (Dr. [unclear])
the day before test

V.

[Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME11267
LICENSE NUMBER

2/12/02
DATE REPORT COMPLETED

1:45 pm.
TIME REPORT COMPLETED

153

Contrast
No procedure
Watson Clinic
C. Brown
S. Brown
S. Brown
S. Brown



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 FEB 19 PM 12:15

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 LLP
City Lakeland Zip Code 33805 County Polk
Name of Physician or Licensee Reporting Dr. Chota Viraopongse

Street Address 1600 Lakeland Hills Blvd
Telephone 813-680-7000
License Number ME00046316

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Name [Redacted]
Local [Redacted]
Patient ID [Redacted]
Diagnosis Cerebral Infarct

[Redacted]
Date of Office Visit 2-7-02
Purpose of Office Visit MR
ICD-9 Code for Diagnosis 434.91

III. INCIDENT INFORMATION

Incident Date and Time 2-7-02 2:02 pm

Location of Incident:
 Operating Rm
 Other X-ray dept 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)

IV in Lt ant/cubital.
Patient seized within 1 min of contrast being
administered during an MR scan of the brain. [Redacted] was
removed from the scan room with a bite stick held
in mouth. [Redacted] seized for approx 2 min. The blue
team was called. [Redacted] was put on O₂ - an IV bag
of 9% saline was hung. Initial BP 220/90 Ream.
O₂ sat 95% -

B) ICD-9-CM Codes

434.91 7055.3
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

7055.3
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

786.39
Resulting Injury (ICD-9 Codes 800-999.9)

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

IV Contrast: Magnevist - Gadolinium

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.

Cindy O'Steen 1734156 Airway
 Tina Atkins 3209332 IV BP's
 Beth Kelp 1089 Airway
 Tina Hanko 1789862 Documentation

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

Elizabeth Oyala 3287

IV. ANALYSIS AND CORRECTIVE ACTION

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

Most likely related to Magnevist + administration, plus renal infant left brain. Patient was revascularized after developing seizures 2-3 minutes IV Valium was given.

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

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

ME 46316
LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

Esophageal perforation after office endoscopy done after conservative surgery died 5 days later

154



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 FEB 21 PM 12:13

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

DEATH

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: Mark Lamet, M.D., P.A. Street Address: 1150 N 35 Ave., Ste 445
City: Hollywood FL 33021 County: Broward Telephone: 954-961-7771
Name of Physician or Licensee Reporting: Mark Lamet MD License Number: ME0037518 / RN2005682
Name of Physician or Licensee Reporting: Denise Kamber R.N.
Locating information for Physician or Licensee Reporting: Same as above

II. PATIENT INFORMATION

Patient Name: [Redacted] Age: [Redacted] Gender: [Redacted] Medicaid/Medicare: [Redacted]
Locating information: N/A
Date of Office Visit: 2/4/2002
Purpose of Office Visit: Upper Endoscopy & Colonoscopy
ICD-9 Code for Diagnosis: [Redacted]

III. INCIDENT INFORMATION

Incident Date and Time: _____ Location of Incident:
 Operating Rm Recovery Rm
 Other Mem Reg Hospital
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 underwent Upper Endoscopy & Colonoscopy on 2/4/02 to evaluate hemoccult positive stool in my office endoscopy suite. ~~St~~ recovery was uneventful & the patient was discharged to SNF. Subsequently developed subcutaneous emphysema & was admitted to Memorial Regional Hospital that evening. Further studies revealed a pharyngeal/esophageal perforation. underwent corrective surgery that evening. Clinical course postoperatively was complicated by cardiac arrhythmia, renal failure & ultimately septic shock. expired on 2/2/02

B) ICD-9-CM Codes

432.35
Surgical, diagnostic or treatment
procedures being performed at time of
incident
(ICD-9 Codes 81-99.9)

E878 ?
~~432.35~~
Accident, event, circumstances, or
specific agent that caused the injury
or event.
(ICD-9 E-Code)

869.1 ?
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)

Olympus Video gastroscope

D) Outcome of Incident (Please check)

<input checked="" 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.

Mark Lamer MD # 037518
Denise Kamsler RN # 2005182 - inserted report, administered Sedation & Recovery

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 inadequately sedated + was combative initially
w/ further sedation the exam was completed easily

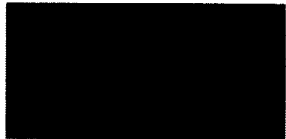
B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Caution, awareness + appropriate use of sedations

V.

Mark Lamer 037518
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

2/15/02 11:00 AM
DATE REPORT COMPLETED 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

02 FEB 25 AM 11:48

DEATH

no procedure

Both MD's
attack?
Died from
+ leg injury
no procedure

OFFICE INFORMATION

MIMA - VIERA
Name of office

7125 Murrell Road

Melbourne 32940 Brevard
City Zip Code County

Street Address

(321) 255-5448
Telephone

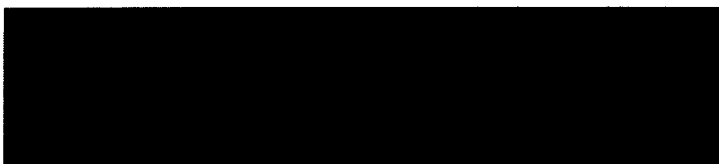
KAREN Andersen - Risk Manager
Name of Physician or Licensee Reporting

LTCRM
License Number

(321) 725-3679 65 E. NASA Blvd
Locating Information for Physician or Licensee Reporting Melbourne FL

Dr. Foley =
Attending

II. PATIENT INFORMATION



Medicaid Medicare

2/18/02
Date of Office Visit

Wheezing
Purpose of Office Visit

786.07
ICD-9 Code for Diagnosis

Diagnosis
Cerebral Palsy, Intractable Spurred
Quadruparisis

III. INCIDENT INFORMATION

2/18/02 1500 Pronounced
Incident Date and Time 15:14

Location of incident:
 Operating Rm
 Recovery Rm
 Other Radiology

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

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

Child brought in by parent for wheezing. Child was somewhat blue on arrival to MD office. Taken to Radiology for CXR. Child coded after X-ray taken. CPR instituted immediately. 911 called. Emergency crews responded within ten minutes. Unable to resuscitate child. MD declared patient expired, and signed death certificate.

B) ICD-9-CM Codes

V81.4
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)

933.1
Resulting injury
(ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

<input checked="" type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input 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.

KEVIN FOLEY, MD ME# 0067529 attending
CRAG SNOW, MD ME# 0069288 Assisting

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

Jennifer Chapman - office Manager
CANDACE JUDAH, MA SCOTT NORVEIL, MA DONNA BROWN, MA

IV. ANALYSIS AND CORRECTIVE ACTION

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

Extremely debilitated, medically compromised child
Death ruled cardiac arrest from natural causes

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

NONE - Staff responded appropriately
Body released to the funeral home

V. Karen Anderson
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

2-19-02
 DATE REPORT COMPLETED

1600
 TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

02 MAR -4 PM 12:08

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

*Fill off
Scale
no hosp
STY
no procedure*



I. OFFICE INFORMATION

FLORIDA COMMUNITY CANCER CENTER 6449 38th AVE N C-3
Name of office Street Address
ST PETERSBURG FL, Pinellas 33710 727 384 3735
City Zip Code County Telephone
ZUREL SOLC MD ME 0037736
Name of Physician or Licensee Reporting License Number & office registration number, if applicable
S/A
Patient's address for Physician or Licensee Reporting 450
Desirea

II. PATIENT INFORMATION

[Redacted] [Redacted]
Age 2/20/02 Gender Male Medicaid/Medicare
Date of Office Visit
CONSULTATION
Purpose of Office Visit
ICD-9 Code for description of incident N/A
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2/20/02
Incident Date and Time
Location of Incident:
 Operating Rm Recovery Rm
 Other SCALE
Note: If the incident involved a death, was the medical examiner notified? VIA 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)

[Redacted] WAS BEING WEIGHED. [Redacted] WALKER WAS OVER THE SCALE TO STABILIZE [Redacted]. WHEN [Redacted] WAS GETTING OFF THE SCALE [Redacted] FELL BACKWARDS.

DR SOLC EXAMINED THE PATIENT, NOTING THAT [Redacted] WAS STABLE. BECAUSE [Redacted] HIT [Redacted] HEAD HE ELECTED TO HAVE THE PARAMEDICS CALLED AND TAKE THE PATIENT TO THE EMERGENCY ROOM. THIS WAS DONE AND PATIENT HAD A CT-SCAN, C-SPINE SERIES AND LAB WORK. [Redacted] WAS RELEASED TO HOME. FILMS-LABS ALRIGHT, SHOWING NO TRAUMA.

B) ICD-9-CM Codes

<u>obtaining weight</u>	<u>Pt. Age + Balance</u>	<u>None</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9E-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)
PARAMETICS USED A COLLAR - BACKBOARD

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>NORRISIDE 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.

CYNDI ARMSTRONG - MEDICAL SERVICES SECRETARY - WAS WEIGHING PATIENT.
DR SOLC ME 0037736

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

LISA BLACK, RTT #29415
BONNIE WILLIAMS, CMO #18699

IV. ANALYSIS AND CORRECTIVE ACTION

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

IT WILL BE STANDARD POLICY THAT WHEN EVER PTS. ARE BEING WEIGHED THE STAFF PERSON IS TO BE BEHIND PATIENT.

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

V.

[Signature] ME 0037736
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
2/21/02 14:00
 DATE REPORT COMPLETED TIME REPORT COMPLETED

[Signature]

V. Tech Cardiac
Chest - After lumbar
Joint injections - no
Deadly



157 STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 MAR -7 AM 11:53

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

DEATH

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

I. OFFICE INFORMATION

Southern Pain Institute
Name of office
Lake Worth, FL 33461 Palm Beach
City Zip Code County
Douglas G. MacLear, D.O.
Name of Physician or Licensee Reporting

4801 S. Congress Ave. Ste. 201
Street Address
561-649-8770
Telephone
OS 3806
License Number

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
[Redacted]
[Redacted]
Osteoarthritis/Osteoporosis
Diagnosis

[Redacted]
[Redacted] Gender [Redacted] Medicaid Medicare
2/28/2002
Date of Office Visit
Spinal Injections
Purpose of Office Visit
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

February 28, 2002 at 1605
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other
Aaron Ruiz 561-688-4575

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] with hx of heart disease presented to clinic routine
lumbar facet injections for ongoing severe back pain. Patient was
given an injection series consisting of 1cc of 0.5% bupivacaine
with 8 mg of triamcinolone at each lumbar level: eight levels in
all. [Redacted] vital signs were stable prior to and throughout the
procedure. The procedure took eight minutes to complete. [Redacted]
received no sedation during the procedure. [Redacted] was taken to re-
covery area and continuously monitored post procedure and [Redacted]
vital signs were normal. Fifteen minutes following the procedure

Page 2 of Synopsis

█ began to vomit. █ then went into Ventricular Tachycardia at a rate of 150 and became unresponsive. █ then developed a pulseless Ventricular Tachycardia and CPR was started. █ was successfully cardioverted, intubated and an IV started. At the time of transfer █ had a heart rate in the 60's and a blood blood pressure of 109/57. Paramedics arrived and the patient was taken to JFK Hospital Emergency Department. The patient later arrested again several times. CPR was eventually unsuccessful and the patient expired at JFK Hospital.

B) ICD-9-CM Codes

<u>Lumbar facet Injections</u>	<u>Heart Disease</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)
64475 X 1 64476 X 5	429.9	

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

D) Outcome of Incident (Please check)

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

Dr. Douglas MacLear #3806 CPR
Dr. Lawrence Gorfine ME31792 CPR
Michael Doyle, R.N. RN1463102
Debra A Bass, R.N. RN1479522

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

Amy Augustine, R.N. RN9177685
Terry Jones, R.N. RN3412772

IV. ANALYSIS AND CORRECTIVE ACTION

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

Dysrhythmia, V-Tach secondary to heart disease

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

CPR started, pt cardioverted X 2, Intubated, Epi, Lidocaine with return of rhythm and systolic BP 109/57. Paramedics took right to JFK Hospital ER.

V.

Dr. MacLear
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT # 3806
3/01/02 **DATE REPORT COMPLETED** 1400 **LICENSE NUMBER**
TIME REPORT COMPLETED

158

STATE OF FLORIDA
Job Bush, Governor

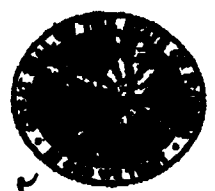
RECEIVED
CONSUMER SERVICES UNIT

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

MAR 11 AM 11:57

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

Fall off
exam table,
clo chair
Pain
no procedure



I. OFFICE INFORMATION

North Florida Radiology PA
Name of office
Gainesville 32605 Alachua
City Zip Code County
Ken Murphy
Name of Physician or Licensee Reporting
Same as Above
Locating information for Physician or Licensee Reporting

6715 NW 11th Pl.
Street Address
352 331 9725
Telephone
RT 29650
License Number

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]
Date of Office Visit
Lumbar Epidural
Purpose of Office Visit
G2311
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

3/7/02 @ 1130
Incident Date and Time

Location of Incident:
 Operating Rm
 Other X-Ray 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)

While the technologist "Lynn Nelson" was clearing the procedure tray the pt. attempted to get off the exam table unassisted. The pt slipped and rolled on to the floor. Pt complained of chest pain after fall. Pt examined by physician vital signs taken, with pt. complaint of chest discomfort EMS was activated. Pt transported to North Florida Regional Medical Center for evaluation and care. Ken Murphy

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-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 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.

Lynn Nelson #31032 North Florida Radiology PA 352-371-9725

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

To instruct all patients not to attempt to get off exam table without assistance.

V.

[Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

29650
LICENSE NUMBER

3/7/02
DATE REPORT COMPLETED

1935
TIME REPORT COMPLETED

159

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 MAR 11 AM 11:56

Fee getting
into hospital
no procedure



OFFICE INFORMATION
Space Coast Medical Associates
Name of office
Merritt Island 32952 Brevard
City Zip Code County

225 Cone Rd.
Street Address
321-453-1361
Telephone

Name of Physician or Licensee Reporting

License Number

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

Patient Identification Number
Recurrent Ovarian Cancer, MDS
Diagnosis

Gender _____ Medicaid Medicare _____
Date of Office Visit _____
Purpose of Office Visit _____
ICD-9 Code for Diagnosis _____

III. INCIDENT INFORMATION

03/05/04, approx 3:15 PM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other treatment room

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

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

PT transferring from wk to bed, lost
balance + fell to floor. PT struck
hip and arm.
Sent to ER for x-rays to R/O fx's.
N.S.

B) ICD-9-CM Codes

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

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

Resulting injury
(ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

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

R.D. Spraws MD

spraws

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

J. Shapiro RN

IV. ANALYSIS AND CORRECTIVE ACTION

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

Bed wheels Not locked.

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

*Bed wheels checked locks engaged before transfer
staff training re transfer from N/C to bed/chair*

V.

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

54026
LICENSE NUMBER

3.5.02
DATE REPORT COMPLETED

17:00
TIME REPORT COMPLETED

Case 72
Dr. B
NO Procedure
Office



160

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 MAR 11 AM 11:51

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

Cancer Centers of Florida
Name of office

Orlando 32806 Orange
City Zip Code County

Rachel Bura
Name of Physician or Licensee Reporting

Cancer Centers of Florida
Locating Information for Physician or Licensee Reporting

52 W Gore St
Street Address

407 426 8484
Telephone

2573882
License Number

II. PATIENT INFORMATION



metastatic Lung Cancer
Patient Identification Number
Diagnosis



3-6-02
Age Gender Medicaid Medicare

Flu Gvax Injection
Date of Office Visit
Purpose of Office Visit

ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

3-6-02 345pm
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 in for follow up and G-VAX Injection. Pt arrived at office short of breath, Dr Simon into see patient O2 Sats checked @ 80% Pt placed on O2 via NC 4Lpm. Pt Sats Rechecked on O2 improved to 85% Pt cont to C/D SOB 9/11 called Pt transported to Orlando Regional Medical Center

B) ICD-9-CM Codes

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

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

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer 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. K. Simon ME 05007658
 Rachel Burg 0573882
 Richard Santomassino
 Lynn Hogue

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 with metastatic lung cancer, progressive disease

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

V. 
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
 3-6-02 540
 DATE REPORT COMPLETED TIME REPORT COMPLETED

Numbers
weakness
extremity
patch for
headache



Cervical Epidural
Have patch
numbers
of spine
at the
neck

161

STATE OF FLORIDA
Job Bush, Governor

RECEIVED
PHYSICIAN OFFICE CONSUMER SERVICES UNIT
ADVERSE INCIDENT REPORT

02 MAR 12 PM 12:07

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

I. OFFICE INFORMATION

FLORIDA PAIN MANAGEMENT
Name of office

5990 54th Ave North
Street Address

ST. PETERSBURG FLORIDA 33709
City Zip Code County

727-545-1270
Telephone

KAZI HASSAN
Name of Physician or Licensee Reporting

ME 0006904
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient
Patient
Patient Identification Number

Age Gender Medicaid Medicare
12/11/02

Diagnosis
Rule out Brachial plexopathy
Radial Median Ulnar
Neuropathy

Date of Office Visit
Purpose of Office Visit
ICD-9 Code for description of incident
Level of Surgery (II) or (III)
Cervical Epidural Injection
Chronic Neck Pain

III. INCIDENT INFORMATION

12/11/01
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 underwent cervical Epidural steroid injection on 12/11/01
for chronic Neck Pain / cervical spinal stenosis
and cervical Bulging disc. developed Post-DURAL Puncture
headache after which PT was given cervical Epidural Blood
Patch. headache decreased but after developed
Numbness and weakness of right upper extremity. At
that time, My diagnosis of numbness and weakness
was due to irritation of cervical nerve root due to
Blood or Local Anesthesia. PT was referred to Dr. Hulley

Neurologist for evaluation and PT is scheduled to be
seen on Dr. Walker who is a
Neuro surgeon for weakness
in PT upper extremity mainly beyond

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-89.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
723.1 / 722.0 / 723.0	Not known yet	But it MAY be the Automatic Blood Pressure Machine

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

Not known yet, But it may be Automatic Blood Pressure Machine

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer -- e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred _____	<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 checked="" type="checkbox"/> Fracture or dislocation of bones or joints <input checked="" 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.

KAZI HASSAN, M.D. - SURGEON. LICENSE - ME66904
 SAROHA PERERA, M.D. - ASSISTANT SURGEON - ME 23234

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

KAZI HASSAN, M.D. - License # - ME66904
 SAROHA PERERA - M.D. - License # - ME 23234

IV. ANALYSIS AND CORRECTIVE ACTION

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

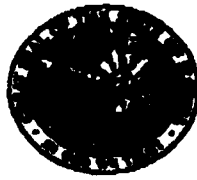
Not known yet - Pt referred to Neurosurgeon Dr. Walker
 Pt was evaluated by Dr. Hulley Neurologist -
 with Radial / Ulnar / Median Nerve neuropathy.

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

The Automatic Blood Pressure machine is taken off the office and is sent to Manufacturer for analysis of BP machine especially calibration

V. Carli Helen MD M 6066904
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
3/5/02 4:12 PM.
 DATE REPORT COMPLETED TIME REPORT COMPLETED

always testing
informed
Test(s)
Fall off Exam
Table
and lacerated hand
NO procedure



162

STATE OF FLORIDA
Job Bush, Governor



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
02 MAR 12 AM 11:28

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

I. OFFICE INFORMATION

Watson Clinic LLP
Name of office
Lakeland 33805 Polk
City Zip Code County
William Hou RN
Name of Physician or Licensee Reporting
1600 LAKELAND HILLS BLVD
Locating information for Physician or Licensee Reporting

1600 LAKELAND HILLS BLVD
Street Address
863-680-7000
Telephone
RN 2515752
License Number

II. PATIENT INFORMATION



[Redacted] Gender Medicaid Medicare
3/4/02
Date of Office Visit
ALWAYS TESTING
Purpose of Office Visit
ICD-9 Code for Diagnosis

Patient Identification Number
800-9
Diagnosis Convulsion unspecified

III. INCIDENT INFORMATION

3/4/02 1:31pm
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other Exam Room

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

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

It was being seen in office for Always testing. Has received intravenous injections. Approximately 5 minutes after last injection pt apparently fell off the exam table on which [redacted] was sitting and struck [redacted] head on cabinet sustaining laceration to occiput of head on muscular to left shoulder. Pt was unattended at the time of the incident. Staff reported pt groggy, responds slowly to verbal questions and did not appear to lose consciousness. After several minutes pt able to make telephone call to mother. [redacted] placed in wheel chair with assistance for safety and taken to Urgent Care Dept after vital signs taken (BP 142/90, RR 20, SpO2 100% on 2L O2 via nasal cannula). Urgent Care physician ordered pt transferred to local hospital emergency room via ALS ambulance. Skin scratch/abrasion - 117; Intracranial test - 32.

B) ICD-9-CM Codes

95004, 95024

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)

850.9 (assault)

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.

All employees of Walter Clinic, Lucille Beauchamp MA (allergy tech), Christine Davis MA (allergy tech), D. Bonini - Allergist ME 0038844, William Hallen RN 251575-2, Jacquelyn Roman RN 2559372
D. Estepian ME 0050693

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)

Pt has possible vague response to injections. Pt did not report any adverse reaction to injections to nurse.

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

All pts receiving allergy testing will remain supine 15 minutes post testing per D. Bonini in reaction to frequent checks on allergy tube.

V.

W. Hunter
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

251575-2 RN
LICENSE NUMBER

3/4/07
DATE REPORT COMPLETED

3:30pm
TIME REPORT COMPLETED



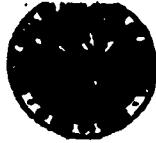
STATE OF FLORIDA
Job Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 MAR 14 PM 12:01

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

5013 rd office
Procedure in 5510
NO procedure



Call next week

MT.
Tait
(813)
254-
4233

I. OFFICE INFORMATION

Hematology Oncology Consultants

Name of office
TAMPA FL 33606
City Zip Code County

Name of Physician or Licensee Reporting
HAFEEZ CHATOOK MD

Labeling information for Physician or Licensee Reporting
AS ABOVE

1414 SWANN AVE
Street Address

(813) 254-7227
Telephone

0060783
License Number

II. PATIENT INFORMATION

ABOVE
Patient Name

Labeling information

COAGULOPATHY
Patient Identification Number
Diagnosis

3/6/02
Age

FOLLOW UP
Date of Office Visit

286.9
Purpose of Office Visit
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

3/6/02 1045
Incident Date and Time

Location of Incident
 Operating Room Recovery Area
 Other OFFICE WAITING AREA

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

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

Patient arrived at MD office at 945 via Red Cross Share Van.
[redacted] OV was for 100. LAB personnel (Liz GILBERT)
drew lab pt did not appear in any distress. Was on O2 per
NC @ 2L from home. Pt was observed by LIZ GILBERT in office
waiting area to be coughing and having difficulty breathing. RD called
to assess (ELLEN SMURRY RD) O2 ↑ to 4L per NC BP 135/48
HR 110. Pt coughing. Dr. Chatook assessed. 911 called.
[redacted] was having wheezing - shortness of breath. [redacted] has h/o
asthma + CHF. Pt. sent to Memorial Hospital.

B) ICD-9-CM Codes

286.9
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 100-149.9)

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

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure
<input type="checkbox"/> Surgical procedure performed on the wrong patient	<input type="checkbox"/> 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 PE SOBREATH	<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.

LIZ GILBERT MLT TL 33795
ELLEN SMILEY RN 0822577
HAFAEEZ CHADOR MD 0060783

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

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analyze (apparent cause) of this incident (Use additional sheets as necessary for complete response)
DA I to 4L per HC, Dr. Chaturvedi, 911 called

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

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

0060783
LICENSE NUMBER

3/6/02
DATE REPORT COMPLETED

1/15
TIME REPORT COMPLETED

Colonoscopy
Chart from
Toby Cardin of 155
Procedure



164

STATE OF FLORIDA
Job Bush, Governor



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
MAR 18 AM 11:46

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: Rafael A. Fleiter, M.D.
City: Miami, FL Zip Code: 33126 County: Dade
Name of Physician or Licensee Reporting: Rafael A. Fleiter M.D.

Street Address: 351 N.W. 42nd Avenue Suite 308
Telephone: 305 643 6806
License Number: ME 35796

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Identification Number: [Redacted]
Diagnosis: Colonic Polyp

Age: 31 Gender: 102 Medicaid Medicare
Date of Office Visit: For colonoscopy
Purpose of Office Visit: 21.3
ICD-9 Code for Diagnosis: 21.3

III. INCIDENT INFORMATION

Incident Date and Time: 3/19/02 @ 11:15 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)

Ad: Although patient was [Redacted] was healthy (ASA I) and recently had been cleared by [Redacted] and myself and tolerated an endoscopic procedure 1 month ago.

PT was brought to the endoscopy suite @ 9:50 AM on 3/19/02. At 9:55 AM and 9:58 AM [Redacted] received 25mg of demerol and 1mg of versed respectively. [Redacted] was fully monitored between 9:50 AM and 10:30 AM with BP, telemetry respiratory rate and oxymeter readings. Procedure ended @ 10:15 AM. Throughout the monitoring period [Redacted] HR, telemetry, BP and oxymeter readings were normal. The last reading showed the following: BP 159/120 HR 84 sinus O2 Sat 94% RR 20. Also, [Redacted] was fully awake and oriented without chest or abdominal pain. At 11:15 AM [Redacted] was going to be discharged when [Redacted] complained of chest tightness and lightheadness. The monitor showed and SVT ca HR of 150, BP 75/40 & RR of 20. [Redacted] O2 Sat was 45%. [Redacted] physical exam was normal except for [Redacted] HR & BP. [Redacted] was given 0.5g of lorazepam and Fire Reewe was called. On arrival @ 11:25 AM [Redacted] BP had ↑ to 214/40 but HR was still 215. Fire Reewe started a new IV and gave [Redacted] adenosine. [Redacted] was transported to Coral Gables Hospital ER and on arrival [Redacted] to the ER had converted to normal sinus and normal [Redacted]

B) ICD-9-CM Codes

45385, 211.3	427.0	none
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer 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. Rafael A. Heita ME 35796
 RN Felix Bustos RN 1017512
 Ernest Monaga R.M.A Reg.# 996537

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 a history of supraventricular tachycardia and cardiologist had held [redacted] lanoxin [redacted] because of bradycardia [redacted] [redacted]

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

V.

M. J. O'Sullivan M.D.
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

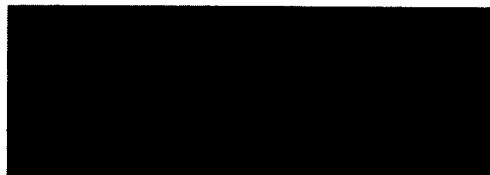
ME 35796
 LICENSE NUMBER

3/12/02
 DATE REPORT COMPLETED

MD
 TIME REPORT COMPLETED

165

STATE OF FLORIDA
Job Bush, Governor



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SERVICES UNIT
02 MAR 21 PH 12:14

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

1 iron infusion
so is of procedure
no procedure

I. OFFICE INFORMATION
Name of office: Hematology Oncology
City: Tampa Zip Code: 33606 County: Hills
Name of Physician or Licensee Reporting: Dr. H. Chatoor
Locating Information for Physician or Licensee Reporting: same as above

Street Address: 1414 Swan Ave.
Telephone: (813) 251-7227
License Number: 0060783

II. PATIENT INFORMATION
Patient Identification Number: [Redacted]
Diagnosis: Iron def. anemia

Age: 61 Medical History: [Redacted]
Date of Office Visit: 1/12/01
Purpose of Office Visit: iron infusion
ICD-9 Code for Diagnosis: 280.9

III. INCIDENT INFORMATION
Incident Date and Time: 1/12/01 19:40p

Location of Incident:
 Operating Room Recovery Room
 Other: office

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

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

pt rec. iron infusion and after completing tx. went into ex rm. with Dr. Chatoor. As [Redacted] was checking out the receptionist, Stacey, notified us (the nurses) that the pt. was having trouble breathing. When we arrived pt. appeared SOB and stated [Redacted] was "lightheaded". O2 per N/C was applied to 2L. bp-142/80 P-100+K-80. Dr. Chatoor was present and asked pt. [Redacted] if [Redacted] wanted to go to the hospital. Pt. replied "yes". We notified [Redacted] sister, whom [Redacted] lives with, and (see other sheet)

▲ sister stated [redacted] lives in [redacted] and still needed to
get dressed. The only other relatives were [redacted] daughter
who lives in [redacted]. We brought [redacted] back to the infirmary
room and placed [redacted] in a recliner. IV was begun in [redacted]
arm and fluids were begun. Dr. Chatoor rec. we call 911 &
we [redacted] transported to the E.R. @ S.S.H. 911 was noti-
fied.

B) ICD-9-CM Codes

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 800-899.9)
---	---	---

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

O2, IV fluids, tubing, #246 needle

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.

Stacy Simmons (same as office) - notified the nurses that patient had BLS RN 958072 (same as office) assessed & assisted with care. called SMILEY RN (same as office) assessed & assisted with care. Kathy Leavitt RN 24554 (same as office) assessed & assisted with care. Dr. H. (noted) 0060783 - assessed & assisted with care.

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)

Hop. 5.5

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

pt transferred to S.I.H. via BLS ambulance

Stacy Clark Lewis 958072
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

11/14/01
DATE REPORT COMPLETED

12/01
TIME REPORT COMPLETED

Vertigo
after diagnosis
injection
no procedure

166



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 MAR 22 AM 11:29



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 Continuicare Medical Group at Lutz
Lutz, FL 33549
City Zip Code County
Daniel Heirig, M.D.
Name of Physician or Licensee Reporting

217 Crystal Grove Blvd., Suite 101
Street Address
813-949-4224
Telephone
ME 47300
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient Identification Number
Diagnosis

[Redacted]
Age 2/12/02 Gender Medicaid Medicare
Date of Office Visit
complaint of Vertigo & Blurred Vision
Purpose of Office Visit
ICD-9 Code for description of incident
N/A
Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

2/12/02 2:30 PM
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 N/A
Was an autopsy performed? Yes No N/A

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

The patient went to the Otolaryngologist (ENT) today at my request because of [redacted] complaint of vertigo, and ear pain. I spoke to the ENT physician and he did not find anything wrong. However [redacted] was having blurred vision and I requested that [redacted] come to the office for an examination. I was concerned about temporal arteritis possibly, with headache, blurred vision, or migraines. I gave [redacted] an injection of 80 mg of Depo Medrol to reduce the inflammation. After the injection, [redacted] became lightheaded and almost passed out. [redacted] blood pressure was 180/90 and [redacted] was positioned in a trandelenburg position. We called 911 and sent [redacted] to the emergency room for evaluation.

B) ICD-9-CM Codes

N/A	E 932.0	.780.2
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)	Resulting Injury (ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

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

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

Dr. Daniel Heinig - Administered injection.

Jayson Noble, Medical Assistant (assisted Dr. Heinig) Address: 10533 Great Falls Lane, Tampa, FL


Amara Williams, Medical Assistant (assisted Dr. Heinig) Address: 8910 Temple Terrace Hwy #4, Tampa, FL

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)
SEE ATTACHED

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

V.  42300
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
3/18/02 _____
 DATE REPORT COMPLETED TIME REPORT COMPLETED

Office incident report: Dr. Heinig

Date of Incident: 2/12/02

IV. Analysis and Corrective Action

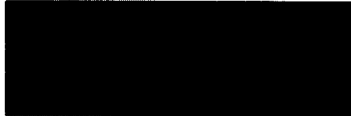
A) Analysis of this incident

The patient presented with blurred vision, headache, and dizziness over the past week. We believe [redacted] fainted as a result of [redacted] presenting condition, rather than as a result of the steroid shot [redacted] received, although [redacted] may also have had a vasovagal reaction to the shot. A pharmacist was contacted after the incident to determine whether the incident could be related to the shot, but we were told less than 1/2 of 1% of patients would have a similar reaction. The patient had also had a steroid shot the previous day with no complications. The patient was transferred to the hospital to be fully evaluated to be sure there was no other underlying cause for the incident. In the hospital, the patient was thought to have otitis media with vertigo as well as basilar migraine, which led to the patient's symptoms.

B) Corrective/proactive actions taken:

As we believe this incident did not occur as a result of medical intervention by the physician, and the physician and staff responded appropriately to the incident, no corrective action has been taken.

167



Came in 5:13 PM
Transferred to hosp.
No procedure



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 MAR 22 PM 1:56

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Southeastern Urological Center, PA.
Name of office

2000 Centre Pointe Blvd.
Street Address

Tallahassee 32308 FL
City Zip Code County

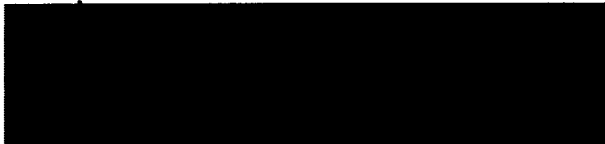
850-201-0408
Telephone

Joseph L. Camps M.D.
Name of Physician or Licensee Reporting

ME57214
License Number & office registration number, if applicable

Same
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 3-13-02 Gender _____ Medical/Medicare _____

Patient Identification Number 17203
Diagnosis Metastatic Prostate Cancer

Date of Office Visit Gross hematuria + anemia
Purpose of Office Visit 399.7

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

III. INCIDENT INFORMATION

3-13-02 9:45 a.m.
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other Exam room

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

A) Describe circumstances of the incident (narrative) (use additional sheets as necessary for complete response)
Patient has known metastatic, terminal prostate cancer. Patient presented to the office diaphoretic, light-headed and nauseated. Foley catheter was draining gross blood with clots. (Had been seen in E.R. the previous night with gross hematuria and hemoglobin of 7.7 - Foley catheter was placed.) Due to patient's condition, [redacted] was transferred to SMH for cystoscopy with clot evacuation and blood transfusion.

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>Sallahassee 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.

<u>Joseph L. Camps, M.D.</u>	<u>ME 57214</u>	<u>Physician</u>
<u>Angie Sougne, R.N.</u>	<u>RN 3006282</u>	<u>Staff Nurse</u>
<u>Jerry Spear, R.N.</u>	<u>91591-2</u>	<u>Child Services Director</u>
<u>Kayl Monello, RHIA, LHRM</u>	<u>5500848</u>	<u>Risk Manager</u>

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

IV. ANALYSIS AND CORRECTIVE ACTION

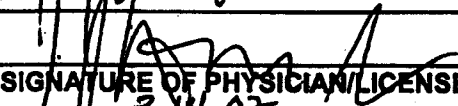
A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Pt. admitted on numerous occasions with gross hematuria + clots secondary to terminal metastatic prostate cancer. This incident was consistent with patient's condition.

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

Patient was appropriately evaluated and transferred to the hospital for further treatment.

V.

	<u>ME 57214</u>
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
<u>3-14-02</u>	<u>3:10 pm.</u>
DATE REPORT COMPLETED	TIME REPORT COMPLETED

Chemo Rx
Pt. colona
Cardiogenic shock
no procedure



168

STATE OF FLORIDA
Jeb Bush, Governor



RECEIVED
CONSUMER SERVICES
02 MAR 29 AM 11:4

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Name of office: Florida Community Cancer Ctr. Street Address: 725 Virginia St.
City: Dunedin Zip Code: 34698 County: Pinellas Telephone: (727) 733.9364
Name of Physician or Licensee Reporting: Linda Montgomery RN OUN
License Number & office registration number, if applicable: _____
Patient's address for Physician or Licensee Reporting: _____

II. PATIENT INFORMATION



Date of Office Visit: 3/19/02 Medical/Medicare
Purpose of Office Visit: chemotherapy / lung cancer
ICD-9 Code for description of incident: 518.4 Pulmonary edema (acute)
20.70 428.1 - left ventricular
Level of Surgery (II) or (III): 705.57 cardiogenic failure +
410.9 MI shock

III. INCIDENT INFORMATION

Incident Date and Time: 3/19/02 1055 AM

Location of Incident:
 Operating Rm. Recovery Rm.
 Other: doctor office - outpatient 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)

Patient discharged from chemotherapy room in stable
condition. returned 5 minutes later, stating
felt awful + something was wrong. c/o SOB,
color pale, then grey. Unable to stand BP 162/88,
in respiratory distress + very loud pulmonary edema
worsening rapidly. O2 5L NCP. applied. 911 called.
Pt. transported to Mease Dunedin ER.

Handwritten signature/initials

B) ICD-9-CM Codes

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

518.4 Pulmonary edema
428.1 left ventricular failure
785.51 cardiogenic shock
410.9 MI
Accident, event, circumstances, or specific agent that caused the injury or event.
(ICD-9 E-Codes)

Resulting Injury
(ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only <u>condition grave</u> Name of facility to which patient was transferred <u>Mease Dunedin 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 RN 3034772
Dr. McAloon MD ME 26552
Responding paramedics

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

Chemotherapy patients

IV. ANALYSIS AND CORRECTIVE ACTION

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

pulmonary edema 2^o cardiogenic shock

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

911 notified

V.

Linda Montgomery RN OCN
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
3/20/02
DATE REPORT COMPLETED

RN 3034772
LICENSE NUMBER

1:00 AM
TIME REPORT COMPLETED

B) ICD-9-CM Codes

Breast Augmentation
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 Apparent
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)

The patient had an IV in place and silicone breast

D) Outcome of Incident (Please check)

implants had been placed

<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>Memorial Hospital Hollywood</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>Alton Ingram MD</u>	<u>FL LIC # 72621</u>	<u>- Surgeon</u>] All can be found at address on p 1
<u>Rona Kaine RN</u>	<u>FL LIC # 2149662</u>	<u>- Anesthetist</u>	
<u>Erin Barrett CST</u>	<u>- 1st Assistant</u>		
<u>Tiffany Alfaya CST</u>	<u>- Assisted & Resuscitation</u>		

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

Hollywood Beach Paramedics, Stirling Road Station

IV. ANALYSIS AND CORRECTIVE ACTION

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

Please See Attached

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

Please See Attached

V. G.S. [Signature] 72621
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
3/26/02 10:45 AM
 DATE REPORT COMPLETED TIME REPORT COMPLETED

Answer to question III A (page one)

██████████ was having breast augmentation surgery. Intravenous sedation was given per the anesthetic record and local anesthetic as well as intercostals blocks were administered. The patient required no additional IV medications (except for the diprivan drip which was started at 9:15) until 9:30. At that time the patient's heart rate went up to 160 and indoral was given intravenously. Shortly thereafter (between 9:30 and 9:35), the patient's systolic blood pressure rose to 180, and 2.5 mg of labetalol was given.

From that point until the placement of the breast implants, which were soaked in iodine, the patient was very stable. ██████████ blood pressure and heart rate descended until they approximated ██████████ preoperative values, and ██████████ did not seem to be in any pain. The Diprivan drip continued to run and ██████████ needed no further medication.

The right-sided breast implant was placed into the pocket at 10:00. At 10:05, the patient's heart rate abruptly dropped to 45, with ██████████ oxygen saturation staying at 99% or greater. We considered treating this bradycardia, but the heart rate spontaneously increased back to the 90-100 range. The left-sided implant was placed at 10:07 and inflation of that implant was begun at approximately 10:10.

Abruptly between 10:10 and 10:15, the patient's heart rate again decreased and this time ██████████ blood pressure also decreased. ██████████ was breathing spontaneously and had an oxygen saturation of 99-100 at that time. As we again prepared to treat the bradycardia, ██████████ became apneic. Surgery was stopped and the patient was resuscitated.

The events from this point until the paramedics' arrival were documented on the date of the event by the anesthetist and this record as well as a narrative I wrote immediately after the incident are included to detail the specifics of the resuscitation.

In summary, the patient's airway and ventilation were secured and the Diprivan drip was immediately stopped. The patient received atropine and epinephrine. Approximately 5 minutes after the onset of the bradycardia, the patient was asystolic. Chest compressions were started and 911 was called. Oxygen saturations of >90% were maintained at the digital saturation monitor throughout the period of CPR. Epinephrine and atropine again were given, and the patient went into ventricular tachycardia which was treated with lidocaine. The rhythm changed to ventricular fibrillation and ██████████ was shocked 3 times and given another ampule of lidocaine. ██████████ rhythm converted to sinus. A lidocaine drip was started and we awaited the paramedics' arrival.

I accompanied the patient in the ambulance to the hospital and turned over ██████████ care to Dr. Salazar. An initial urine toxicology screen reportedly was positive for benzodiazepines (prescribed for anxiety and given at the start of the case) as well as cocaine, marijuana, and amphetamines. A later test of a second specimen was inconsistent with either the previous test or the medications the patient was known to have taken pre- and intraoperatively.

Proposed

ACB
3/24/02

Answers to Question IV (page 2)

IV-A:

The apparent cause is not completely clear. [REDACTED] does not seem to have had a reaction to the local anesthetic or to the agents given intravenously at the start of the case due to the time course. The inderal and labetalol similarly seem to have been given long enough in advance of the occurrence to rule them out as the cause. The Diprivan drip was running up to the point of the patient's bradycardia, but it was continually observed to be running at an appropriate rate, and the patient's respiratory rate was not depressed until after the onset of the event.

The time course of the patient's event suggests that it may be related to the instillation of betadine into [REDACTED] implant pockets. While there was no injection into the vascular system or the muscle, there are always interrupted blood vessels in a dissected implant pocket, and a high systemic absorption of betadine is possible.

Finally, an interaction of licit and illicit drugs is possible. The two urine toxicologies were contradictory and the second test did not turn up drugs known to have been ingested by the patient.

IV-B

I am in the process of reviewing our policy with regard to preoperative toxicological testing as well as our emergency protocols. After this review, I plan to discuss the above in a formal setting with all of the staff.

ACB
3/26/02

170



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT 02 APR -4 AM 11:58

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

H/A, Med. Dir.
Name of Physician
no procedure



I. OFFICE INFORMATION

Southeastern Urological Center
Name of office

2000 Centre Court Blvd.
Street Address

Tallahassee 32308 Leon
City Zip Code County

850-201-0408
Telephone

David D. Miles, M.D.
Name of Physician or Licensee Reporting

ME 0011502
License Number & office registration number, if applicable

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

II. PATIENT INFORMATION



Age 2/27/02 Gender Male Medical Insurance Medicare

Date of Office Visit Preoperative Lab Tests

Purpose of Office Visit 789.01

ICD-9 Code for description of incident N/A

Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

2/27/02 2:00 p.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 presented to office for the purpose of obtaining preoperative lab tests. While in the office, [redacted] complained of a headache, abdominal pain, and nausea. Became somewhat hypotensive and an IV was started. Patient had past medical history of cardiac problems and is diabetic. Blood sugar was 222. Primary care M.D. was called and requested that patient be transferred to JMH E.R. for further evaluation.

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 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>Sallahassee 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.

<u>David D. Miles, M.D.</u>	<u>ME 0011502</u>
<u>Jerry Spear, RN</u>	<u>91591-2</u>
<u>Marilyn Ford, RN</u>	<u>2020262</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)

Cause of symptoms unknown at time of office visit. felt unrelated to patient's neurological diagnosis (BPH).

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

Patient evaluated and appropriately transferred to hospital for further evaluation by primary physician.

V.

David D. Miles, M.D.
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
4-3-02
 DATE REPORT COMPLETED

ME 11502
 LICENSE NUMBER

9:50 a.m.
 TIME REPORT COMPLETED

Fell
trying onto
exam table.
broke hip
NO procedure



STATE OF FLORIDA
Job Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
02 APR - 9 AM 10:32

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

Primary Mailing Address
2615 Central Ave Ste 7
FT Myers, FL 33901
Telephone
(941) 275-1170
License Number
ME0071219

Office Site @ Incident
9991 Healthpark Circle
Suite 279 Ft Myers 33908

I. OFFICE INFORMATION
Name of office
Associates in Pulmonary Medicine
see next column
City
KENNETH TOLEP
Zip Code
County
Name of Physician or Licensee Reporting
see addresses
Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION
[Redacted]
Patient Identification Number
Dr. COPD
Diagnosis

Age
April 2, 2003 2002
Gender
Medical History
Date of Office Visit
Evaluation + treatment of COPD
Purpose of Office Visit
496
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION
Incident Date and Time
April 2, 2003 (3:45-4PM)
1102

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)

[Redacted] was seen in this office 4 times previously.
[Redacted] lives independently, [Redacted] to the office & had been the
prime caregiver to [Redacted] before [Redacted] died. On arrival, our
staff observed that the patient could move onto and
off from the exam table without assistance. When I came
into see the patient, [Redacted] was sitting in a chair without signs of
respiratory distress. [Redacted] easily participated in the interview -
history taking. [Redacted] did not initiate any unsteady sort of syncope.
I was summoned out of the room to speak to the Embroidery Dept.

When I came back to the exam room, the patient was on the floor, having fallen trying to get onto the exam table. ■ did have leg pain. The staff and I carefully helped the patient onto a wheelchair and brought ■ to the ER on supplemental oxygen. ■ was immediately attended to by the ER attending and a respiratory therapist (I was out of the patient's room for ≤ 2 minutes). Orthopedic Surgery was consulted + successful orthopedic surgery was completed. K. P. W.

B) ICD-9-CM Codes

496
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)

Hip Fracture 820.8
Resulting Injury (ICD-9 Codes 800-999.9)

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

NONE

D) Outcome of Incident (Please check)

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

Jennifer Giammaristo - took vital signs on patient (when patient initially arrived (see narrative) works as staff at Healthport office location)

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

Alan Siegel, M.D. ME 039098

IV. ANALYSIS AND CORRECTIVE ACTION

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

The incident was not predictable/preventable. However, in the future, patients will remain safe unless they are accompanied by family, friends or staff. see below.....

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

→ We will ask them if they are able to go to exam table without assistance, and if not, assistance + supervision will be provided.

V.

Kenneth Telf M.E. 0071219
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
4/4/02 1 PM
DATE REPORT COMPLETED TIME REPORT COMPLETED

FROM :

PHONE NO. :



172

STATE OF FLORIDA
Job Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT

02 APR 11 PM 12:03

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

Handwritten notes:
Hair Transplant
Seizure ?
Procedure received
NOT STATED. NO PROBLEM
NO SEIZURE

I. OFFICE INFORMATION

Bernard P. Nusbaum, M.D., P.A.
Name of office

7867 N. Kendall Dr.
Street Address

tomorrow

Miami FL 33156 Dade
City Zip Code County

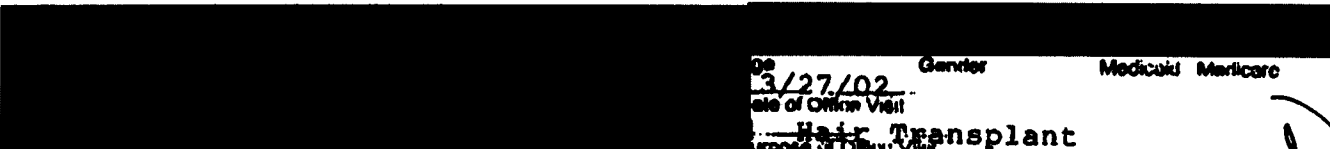
(305) 274-2202
Telephone

Bernard P. Nusbaum, M.D.
Name of Physician or Licensee Reporting

037143
License Number

7867 N. Kendall Drive; Miami 33156
Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION



3/27/02 Gender Male Medical Medicare

Date of Office Visit

Purpose of Office Visit Hair Transplant

ICD-9 Code for Diagnosis 704.00

Male Pattern Alopecia
Diagnosis

III. INCIDENT INFORMATION

3/27/02 3:20 p.m.
Incident Date and Time

Location of Incident:
 Operating Room
 Other

Recovery Room

Handwritten notes:
(18/ads = 10 mg/hal)
NOT a TOXIC
Dose.

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)

Patient received Halcion 0.5 mg p.o. and Cephalexin 500mg p.o. 30 minutes prior to the incident. During the infiltration of xylocaine with epinephrine local anesthesia (224 mg of xylocaine given) the patient had a change in mental status with rigidity. I administered oxygen by nasal canula and gave 3 doses of IM Valium 5 mg, 2.5 mg and 2.5 mg and called 911. The patient improved with the above treatment. During the episode BP was 160/100 and oxygen saturation was within normal limits. Rescue transferred the patient to Baptist Hospital of Miami without further treatment. I followed and consulted with the Emergency room physician upon the patient's arrival to the E.R.



STATE OF FLORIDA
Jeb Bush, Governor

**PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT**

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

I. OFFICE INFORMATION

Name of office _____

Street Address _____

City _____ Zip Code _____ County _____

Telephone _____

Name of Physician or Licensee Reporting _____

License Number _____

Locating Information for Physician or Licensee Reporting _____

II. PATIENT INFORMATION

Patient Name _____

Age _____ Gender _____ Medicaid Medicare

Locating Information _____

Date of Office Visit _____

Patient Identification Number _____

Purpose of Office Visit _____

Diagnosis _____

ICD-9 Code for Diagnosis _____

III. INCIDENT INFORMATION

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)

(cont.)

The patient was admitted to the hospital and developed transient neurologic signs during the hospital stay. While hospitalized the patient had MRI's, CT's and EEG and MRA which were normal. Patient was discharged without any residual deficits. I consulted with the treating neurologist and the diagnosis was: probable seizure-type reaction to medication.

no source

