Adverse Incident report 11/24/03
Citrus Hematology & Oncology Center

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øtnrbal12/2.16              MAINTAIN ANY LICENSE DATA              1501/MED-MEø
øFile: 76953                                                                 ø
øSSN: [redacted]         Medical Doctor                                      ø
øLic:  81376             CLEAR,ACTIVE                                        ø
øName: SERVILLANO ESTRADA DELA CRUZ JR (DBA:0 Old:0)                         ø
øAddr: 1809 E. HARTFORD STREET                     State:  FL                ø
ø                                                  Zip:    34453             ø
øCity: INVERNESS                                   County: CITRUS            ø
ø                                                                            ø
øCertificate No: 62262      First License:   10/26/2000                      ø
ø     "    Date: 11/29/2001 In Rank Since:   10/26/2000                      ø
øLast Renewal:   11/28/2001 License Method:  1021,INITIAL,ENDORSE            ø
øCurrent Expiry: 01/31/2005 Renewal Notice:  10/23/2001                      ø
ø                           In Directory?    N  Include                      ø
øStatus Date:    10/26/2000 Fee Exempt?      N                               ø
øNote:                                                                       ø
ø                                                                            ø
ø                                                                            ø
øAction:  Query  Transfer  A-Address  B-Basic_Data  C-PSD  D-Contact_Hst ... ø
ø         Go to view only options                                            ø
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Adverse Incident Report 11/24/03

Citrus Hematology & Oncology Center

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øtnrbal31/2.2              DISPLAY SUBORDINATE LICENSES             1501/MED-MEø
ø SUPERIOR                                                                    ø
ø File: 76953                                                                 ø
ø SSN: [redacted]      Medical Doctor                                         ø
ø Lic:   81376         CLEAR, ACTIVE                                          ø
ø Name: SERVILLANO ESTRADA DELA CRUZ JR                                       ø
ø Addr: 1809 E. HARTFORD STREET                State:  FL                     ø
ø                                              Zip:    34453                  ø
ø City: INVERNESS                              County: CITRUS                 ø
ø                                                                             ø
ø                                                                             ø
ø                                                                             ø
ø   ìñê RelationID Rank Status          Act Status     Count Max Item 1 of 20 ø
ø   ø1ø ALTER-SUP  RS   OBLIGATIONS     ACTIVE         0                      ø
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øAction:   Select  List  Exit                                                 ø
ø          Select supporting license                                          ø
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OSR [redacted] 88

267

211

STATE OF FLORIDA
Jeb Bush, Governor

[redacted] RECEIVED
CONSUMER SERVICES UNIT
03 DEC -3 AM 7:57

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Southeastern Urological Center
Name of office

2000 Centre Point Blvd
Street Address

Tallahassee | 32308 | Leon
City | Zip Code | County

850 - 201-0402
Telephone

H. Dave Sawyer, MD
Name of Physician or Licensee Reporting

ME 27104
License Number & office registration number, if applicable

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

suture removal - no procedure

II. PATIENT INFORMATION

[redacted]
Patient Identification Number

Bladder Cancer
Diagnosis

[redacted] Age ☐ Gender ☐ Medicaid ☐ Medicare

11-24-03
Date of Office Visit

staple removal post op
Purpose of Office Visit

998.3
ICD-9 Code for description of incident

NA
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11-24-03 @ 0930
Incident Date and Time

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☒ Other: Physician office

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

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

Patient arrived for staple removal post left ureterostomy. The nurse assessing the wound asked for a second opinion by the Charge nurse. The wound was noted to be reddened, warm to touch extending laterally on both sides several inches with purulent drainage at the sites of exit of all stay sutures bilaterally. Dr. Sawyer was asked to assess wound and after doing so removed the staples. The wound dehisced approximately 2/3 its length. The wound was dressed and the patient was transported via Ambulance to TMH for admission. End Section.

Form # DH-MQA1030- created 2-00; revised 9-6-01

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)
		998.32

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

D) Outcome of incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure
- ☐ Any condition that required the transfer 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

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure

** If it resulted in

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function;
- ☐ Any condition that required the transfer 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. H.P. Sawyer MD — Physician

Juanita Fitzlehner RN — Nurse caring for p

Terry J Spear RN — 91591-2 – Charge Nurse

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

Patient was quite obese and it would not be uncommon with [redacted] other medical problems to dehisce [redacted] wound.

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

Patient transferred for continued care and by ambulance to guard against further trauma.

V. Terry J Spear RN — SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

915912 — LICENSE NUMBER

11-25-03 — DATE REPORT COMPLETED

1900 — TIME REPORT COMPLETED

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otnrbal12/2.16                MAINTAIN ANY LICENSE DATA                1501/MED-Mo
oFile: 19969                                                                   o
oSSN: [redacted]      Medical Doctor                                           o
oLic:  27104          CLEAR,ACTIVE                                             o
oName: WILLIAM P SAWYER M.D. (DBA:0 Old:1)                                     o
oAddr: 2000 CENTRE POINTE BLVD                    State:  FL                   o
o                                                 Zip:    32308-4611           o
oCity: TALLAHASSEE                                County: LEON                 o
o                                                                              o
oCertificate No: 69922          First License:  09/20/1976                     o
o     "     Date: 12/15/2001    In Rank Since:  09/20/1976                     o
oLast Renewal:  12/14/2001      License Method: EXEN                           o
oCurrent Expiry: 01/31/2005     Renewal Notice: 10/20/2001                     o
o                               In Directory?     Include                      o
oStatus Date:   01/01/1801      Fee Exempt?     N                              o
oNote:                                                                         o
o                                                                              o
o                                                                              o
oAction:  Query  Transfer  A-Address  B-Basic_Data  C-PSD  D-Contact_Hst ...  o
o         Go to view only options                                              o
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                  1 Sess-1    167.78.1.20                          1 22/9
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FROM : PHONE NO. :

200330077
H1A05

2683
212

American Board Plastic Surgery
~~no board certification~~
Southshore hospital privi
+ AAAAHSF accredited

STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Sunny Island Cosmetic Surgery
Name of office

19495 Biscayne Blvd. Suite 201
Street Address

Aventura 33180 Dade
City Zip Code County

(305)932-9877
Telephone

Fabio Arturo Castro
Name of Physician or Licensee Reporting

ME87481
License Number & office registration number, if applicable

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

II. PATIENT INFORMATION

[redacted]

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

First Visit Oct. 21, 2003
Date of Office Visit

N/A
Patient Identification Number

Plastic Surgery Consultation
Purpose of Office Visit

Fat Embolism
Diagnosis

ICD-9 Code for description of incident

III
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Surgery 11/24/03 Transfer approx. 9:00 pm
Incident Date and Time

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

Note: If the incident involved a death, was the medical examiner notified? ☒ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No
Not information at this time

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

See Attachment

RECEIVED
CONSUMER SERVICES UNIT
03 DEC 15 PM 2:32

Form # DH-MQA1030- created 2-00; revised 3-24-03

Liposuction - fat transfer → fat embolism? → death after 9 days
General anesthesia
MD anesthesiologist

B) ICD-9-CM Codes
LIPOSUCTION & FAT TRANSFER TO BUTTOCKS / FAT EMBOLISM / DEATH

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

- [X] Death
- [ ] Brain Damage
- [ ] Spinal Damage
- [ ] Surgical procedure performed on the wrong patient
- [ ] A procedure to remove unplanned foreign objects remaining from surgical procedure
- [ ] Any condition that required the transfer outcome of the patient to a licensed hospital

Outcome of transfer – e.g., death, brain damage, observation: _____
Name of facility to which patient was transferred: AVENTURA HOSPITAL

- [ ] Surgical procedure performed on the wrong site **
- [ ] Wrong surgical procedure performed **
- [ ] Surgical repair of injuries or damage from a planned surgical procedure

** If it resulted in

- [X] Death
- [ ] Brain Damage
- [ ] Spinal Damage
- [ ] Permanent disfigurement not to include the incision scar
- [ ] Fracture or dislocation of bones or joints
- [ ] Limitation of neurological, physical, or sensory function:
- [ ] Any condition that required the transfer 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.

FABIO A. CASTRO M.D.	ME 87481	SURGEON
NIKOLA BOSKOVSKI M.D	ME 50634	ANESTHESIOLOGIST
CANDI BOTERO R.N	RN 9175492	

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)
FAT EMBOLISM

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

V. F. Castro ME87481
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — LICENSE NUMBER

12/10/2003 — DATE REPORT COMPLETED
5:00p.m. — TIME REPORT COMPLETED

Form # DH-MQA1030- created 2-00; revised 3-24-03

Attachment:

After liposuction the patient was placed in recovery room in stable condition: Blood Pressure 125/80 heart rate 86 respiration rate 16 SO2 96. Later during [redacted] stay in recovery patient SO2 dropped to 89 and supplement oxygen was given with temporarily improvement, next [redacted] respiratory rate and [redacted] heart rate increased, 100% oxygen was given and patient communicated with us that [redacted] was getting anxious, we made the decision to transfer to the hospital for further evaluation and treatment for suspicion of fat embolism. Patient was intubated and 911 was called, the patient was transferred to the emergency room to the Aventura Hospital. The patient was treated in Intensive Care for nine days and after complication died.

269

[redacted]

[redacted]

STATE OF FLORIDA
Jeb Bush, Governor

[redacted]

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
04 JAN 12 PM 3:28

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

52 W. Gore St.
Street Address

Orlando, Fl. 32806 Orange
City Zip Code County

407-426-8484
Telephone

Amanda M. Allen
Name of Physician or Licensee Reporting

1951592
License Number

52 w. Gore St. Orlando Fl 32806
Locating Information for Physician or Licensee Reporting

no procedure

II. PATIENT INFORMATION

[redacted]

Patient Identification Number

Age General Medicaid Medicare

leukemia
Diagnosis

1-6-04
Date of Office Visit

Chemotherapy administration
Purpose of Office Visit

204.00
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

1-6-04
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

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Pt received intrathecal chemotherapy administered by Dr Barry Berman. Pt became nauseated and had multiple episodes of emesis. Pt's blood pressure became elevated. Pt was treated with personal meds (clonidine 0.1mg S.L). Pt had more emesis and was unable to hold meds under [redacted] tongue. 911 was called and patient was transported to the emergency department. Pt was AAOX3 but continued to have ↑ B/P. Pt has a history of hypertension. Pt was normotensive at initiation of therapy.

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)

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

** if it resulted in

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function
- ☐ Any condition that required the transfer of the patient

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

Dr. Berman ME56669
Amanda M. Allen 195592

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 initial vasovagal incident and resulting hypertension

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

V.

Amanda M Allen — SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

195592 — LICENSE NUMBER

1-7-04 — DATE REPORT COMPLETED

12:36 — TIME REPORT COMPLETED