

JAN-20-2004 TUE 04:24 AM

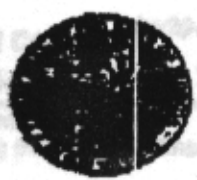
FAX NO. [REDACTED]

1/19/2004 18:51 FAX 561 988 0655

UNIVERSAL HEALTHCARE INC

001

1270
[REDACTED]



no AAAHC accredit.

STATE OF FLORIDA
Jon Bush, Governor

Board of American Board of Plastic Surgery
no accredit.

no AAAHC accredit

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32309-0275

I. OFFICE INFORMATION
Name of office: Florida Center for Cosmetic Surgery
City: Sunrise Zip Code: 33304 County: Broward
Physician Name: Roger Gordon, MD
Federal address for physician or licensee reporting: see below

915 Middle River Dr.
Office Address
Telephone: 954-565-7575
OSR 38
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[REDACTED]
Diagnosis: macromastia

Date of Office Visit: 1/19/04
Purpose of Office Visit: outpatient HE report
Level of Surgery (I) or (II): III

III. INCIDENT INFORMATION

Incident Date and Time: 1/19/04 Florida Medical Center

Location of Incident:
 Operating Room Recovery Room
 Other

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

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

Pt underwent abdominoplasty + breast reduction on 1/19/04 & having been cleared by her personal internist + rheumatologist as well as 2 anesthesiologists. plastic surgeon. Surgery was uneventful - pt was transferred to ICU in stable condition. In ICU pt had episodes of hypotension which was corrected + fluid administration under the guidance of an MD anesthesiologist. Pt was DIC in stable cond. Pt returned to facility on 1/21/04 seen by Med. Dir. Pt AA-O, ambulation 5 diff, T-99. Version's C-12-1, instructions given to pt - [REDACTED] Pt [REDACTED] called facility at 4:45 pm to ask if she could wash [REDACTED] Sometime between 6:00-7:00 pm pt was taken by 911 to Florida Medical Center where she was admitted to the ICU in respiratory + renal failure. Pt was under the care of the ICU at our [REDACTED] Pt expired on 1/21/04.

A bdsuwp lary/breast reduced 1/19/04 incl general by MD anesthesiologist - resp. renal failure - death

B) ICD-9-CM Codes Fluoromastectomy 86.83
total Reduction Hemorrhage 85.52 unknown 799.9
 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 81-86.9) Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code) Resulting injury (ICD-9 Codes 800-899.9)

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

D) Outcome of incident (Please check)

<input 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 results 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 outcome of the patient to a licensed hospital	<input type="checkbox"/> Brain Damage
Outcome of transfer - e.g., death, brain damage, observation only <u>death</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred <u>Florida Medical Center</u>	<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, including information, and the capacity in which they were directly involved with this incident.

Roger Gordon, MD - Plastic Surgeon ME 82538 Louides Rodriguez, HA
Anthony Wicks MD - anesthesiologist ME 31657 circulator
Jeffrey Thomas MD - Medical Director ME 46016 Miguel Anton, HA
Ena Bacelar, RN - PACU Nurse RN 321372 scrub

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

cause of death unknown - pending medical examiner's report

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

no corrective action appeared indicated @ this time

V. Roger L Gordon MD ME 82538
 SIGNATURE OF PHYSICIAN/LICENSÉE SUBMITTING REPORT LICENSE NUMBER
1/19/04 1615 HJ
 DATE REPORT COMPLETED TIME REPORT COMPLETED

OSR 124
N/U File

2004032

NA

274



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: Watson Clinic
City: Lakeland Zip Code: 33804 County: Polk
Name of Physician or Licensee Reporting: B. G. Gussess RN
Patient's address for Physician or Licensee Reporting: Watson Clinic, 1600 Lakeland Hills Blvd, Lakeland, FL

Street Address: 1600 Lakeland Hills Blvd
Telephone: 863-680-7859
License Number & office registration number, if applicable: RN 1751902

II. PATIENT INFORMATION

Patient Name: [Redacted]
Patient's Address: 159067
Patient Identification Number: [Redacted]
Diagnosis: lung CA

Age: 1-19-04 Gender: [Redacted] Medicaid: Medicare:
Date of Office Visit: 1-19-04
Purpose of Office Visit: Flu Lung Ca. Cat Scan #162
ICD-9 Code for description of incident: NA
Level of Surgery (II) or (III): [Redacted]

no procedure

III. INCIDENT INFORMATION

Incident Date and Time: 1-19-04

Location of Incident:
 Operating Rm Recovery Rm
 Other: Cat Scan

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

A) Describe circumstances of the incident (narrative)

Responded to Code 99 in Cat Scan Pt. here for Flu Lung Ca. Cat Scan in progress. Contrast was given shortly after Radiology tech felt pt had breathing problems - team responded. Unable to get BIP even E doppler - IV was in place fluid opened - Pt was breathing E freq periods of apnea - Apical audible thru LA cont. rhonchi / rales - Soluacet & epi given IV - pt responsive on transfer to EMS -

RECEIVED
CONSUMER SERVICES UNIT
04 FEB - 2 AM 8:14

052124
N/A File
2004032
1/14

STATE OF FLORIDA
Jeff Bush, Governor

B) ICD-9-CM Codes ^{ICD} #162

Cat Scan c contrast no code. adverse event

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)

SUBMIT FORM TO:
Department of Health
Office Box 14000
Tallahassee, Florida 32317-4000

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 _____	<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.

Cindy Osteen RN 1751782 Bunny Grypanso 1751902 Pat Card
Paula Lander 1750412 Kim ARNP 3069
Debych RN - PN-112865
Dr. Kramer, Dr. Riche, Dr. Amin

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

Michelle Buhm - tak.

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

V. [Signature] 1751902
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
1-19-04 3:00 pm
DATE REPORT COMPLETED TIME REPORT COMPLETED

1272
216



STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

Am Ctr.

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
Tallahassee 32308 Leon
City Zip Code County
Joseph L Camps MD
Name of Physician or Licensee Reporting
Same
Patient's address for Physician or Licensee Reporting

200 Centre Pointe Blvd
Street Address
850-309-0400
Telephone
ME 0057214
License Number & office registration number, if applicable

no procedure

II. PATIENT INFORMATION

[Redacted]
Patient Identification Number
neurogenic bladder status
Diagnosis: post stroke

[Redacted]
1-20-04
Date of Office Visit
follow up for neurogenic bladder
Purpose of Office Visit
NA
ICD-9 Code for description of incident
NA
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1-20-04 @ 1015 AM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other MD 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 routine office visit, spoke with MA preparing [redacted] for the doctor. MA left the exam room and within minutes the patient's [redacted] called out for help. Upon entering the room Dr. Camps and Ms. Clark noted the patient to be diaphoretic, unresponsive, with a thready pulse. EMS called for transport to TMH. The patient was in [redacted] own wheelchair and was not moved until EMS arrived. The patient would respond when physically aroused by [redacted]. Dr. Camps spoke with Dr. Coararo in the ER for follow up care.

RECEIVED
CONSUMER SERVICES UNIT
JAN 27 AM 11:58

B) ICD-9-CM Codes

NA
NA
NA

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
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C) List any equipment used if directly involved in the incident

(Use additional sheets as necessary for complete 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
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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.

Joseph K Camps MD ME0057214
Patricia Clark MA

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

[Redacted]

IV. ANALYSIS AND CORRECTIVE ACTION

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

Thought that this patient may have experienced another stroke. Transfer to acute care facility for further treatment and diagnosis is appropriate care.

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

Patient was appropriately transferred to an acute care facility via EMT.

V. Jerry Spear RN 915912
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
1-20-04 11:30 Am
 DATE REPORT COMPLETED TIME REPORT COMPLETED

02/24/2004 11:07 AM: 001 000 0000

UNIVERSAL HEALTHCARE INC

002
OSR
242
001/003

273
277



STATE OF FLORIDA
Joe Bush, Governor
PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Customer Service Unit
6000 Blvd Cypress Way, RM 670
Tallahassee, Florida 32304-3070

L OFFICE INFORMATION

Florida Center for Cosmetic Surgery - WPS
1001 Palm Bch Palm Bch
Frank Larcadeo MD
5500 Pacific Blvd Boca Raton FL

1501 Forest Hill Blvd
(561) 964-0001
OSR 242

PATIENT INFORMATION
[Redacted]
11/7/03
closure of wound
of abdominoplasty

11/7/03
closure of wound
of abdominoplasty

M INCIDENT INFORMATION

1/colad - see below

Location of incident: see below
□ Operating Room
□ Recovery Room
□ 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)

Pt underwent abdominoplasty on 11/7/03. Pt is heavy smoker and had small area of delayed healing. Open wound at incision. On 11/7/03, Dr. Larcadeo performed an exploration and closure of wound under local anesthesia. On 11/7/03, called office stating there was an area of redness that was sore. [Redacted] had a Shingles virus. Pt told to come in to be evaluated by MD. Pt refused. Pt of 11/7/03 left message on back line answering machine. Pt went to [Redacted] ER where [Redacted] was admitted. Cellulitis. Pt had a large amount of wound on 11/7/03 in the ER at [Redacted] by Dr. [Redacted]. Pt is being treated with antibiotics & they planning underway.

Abdominoplasty 11/7/03 -> cellulitis -> admitted

B) ICD-9-CM Codes
Surgical diagnosis, or procedure
procedure being performed at time of
incident
(ICD-9 Code 91-93.9)

*Note - pt was
informed on consent
998.5 - Distal negative
infection*
Apply one, event, or condition, or code
used to report that caused the injury
or event.
(ICD-9 E-Code)

C) List any equipment used if directly involved in the incident.
(An additional sheet is necessary for complete report)

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 checked="" type="checkbox"/> Surgical repair of injury or damage following 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 implanted foreign objects resulting 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"/> Any condition that required the transfer of the patient to a licensed hospital	<input type="checkbox"/> Spinal Damage
Outcome of transfer - e.g., death, brain damage, observation only, etc. (Use ICD-9-CM code for transfer of body to which patient was transferred.)	<input type="checkbox"/> Permanent impairment not to include the transfer only
ICD-9 Emergency Classification	<input type="checkbox"/> Fracture or dislocation of bones or joints
ICD-9-CM Code	<input type="checkbox"/> Loss of neurologic, physical, or sensory function
ICD-9-CM Code	<input type="checkbox"/> Any condition that required the transfer outcome of the patient

E) List all persons, including license numbers if licensed, training information, and the capacity in which they
were involved.

Nichole Brown - MA, assisted dental - spoke to pt.

F) List witnesses, including license numbers if licensed, and training information if not listed above
as above.

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analyze (report if caused) of this incident and outline steps to prevent its complete recurrence

*Post-operative wound infection allowed to
progress because I was not informed
that the patient was having severe pain i. nausea
All messages to physician must be given
to physician in timely fashion*

V. *Signature*
SIGNATURE OF PHYSICIAN/CLERK IS SUBMITTING REPORT
DATE REPORT COMPLETED
TIME REPORT COMPLETED
ME 06345
LICENSE NUMBER

Facility Administrator
Penny Linch
2/9/2004

We have implemented the following two new requirements of all Medical Assistants within our facility.

1. Each patient must be given a verbal explanation of how important it is to utilize our main phone number when calling the center. The dialogue will be used as part of our post operative instruction list and is as follows-

" Please be sure to us: ONLY the main telephone number listed on all of the FCCS forms, etc. and not any of the numbers you may get off of your caller ID.

Your calls are important to us and if it is after our normal hours of operation we want to be sure to receive them. Our answering service will pick up only on the main line and the service will reach the appropriate person or doctor who can assist you."

2. All post operative patient telephone calls to the center must be listed in the call registry with the reason for their call clearly indicated. Each registry should then be reviewed and signed off by the physician on a daily basis at the Doctors earliest availability. The MD will make any necessary patient calls at his discretion. All emergency calls must be forwarded the doctor immediately.

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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



274
American Board of Plastic Surgery
Mease Hospital Privileges
AAAAASF accredited

I. OFFICE INFORMATION

Name of office Palm Harbor Plastic Surgery Centre

City Palm Harbor Zip Code 34684 County _____

Name of Physician or Licensee Reporting Erel Laufer, M.D.

Patient's address for Physician or Licensee Reporting

35080 US Hwy 19 North
Street Address

(727) 789-5711
Telephone

ME 41440
License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Identification Number

Diagnosis Hypomastia

Age 02/18/04 Gender _____ Medicaid Medicare

Date of Office Visit _____

Purpose of Office Visit Surgery of breasts

ICD-9 Code for description of incident 19.325

Level of Surgery (II) or (III) III

III. INCIDENT INFORMATION

Incident Date and Time 02/18/04 1600

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)

During surgery patient noted with hives over body. Benadryl given IV with positive outcome. Hives and itching re-occurred in recovery room. Multiple medications given IV with minimal effect. Sent 911 to Mease Countryside Hospital for evaluation.

RECEIVED
ENROLLMENT UNIT
MAY 27 AM 11:20

Breast Aug -> general by MS over the shoulder 10 -> on schedule

B) ICD-9-CM Codes

Breast Augmentation

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)

Anaphylaxis

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)
Observation due to anaphylaxis

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 to hospital
Name of facility to which patient was transferred Mease Countryside Hospital Safety Harbor, Florida

- 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.

Karl Swanson, M.D. - anesthesiologist ME 60975
Erel Laufer, M.D. - surgeon lic# ME 41440
Crystal Hammer, L.P.N. - recovery room nurse PN 1199621

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)

Allergic to anesthesia drug

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

Patient was discharged from Hospital and taken home where [redacted] was resting. The recovery room nurse called patient at home and [redacted] was feeling better.

V.

Erel Laufer M.D.
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

41440
LICENSE NUMBER

4/19/04
DATE REPORT COMPLETED

4 PM
TIME REPORT COMPLETED

12-75
29



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT
MAR 10 PM 2:59

DEATH

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

I. OFFICE INFORMATION

FL Cancer Institute
Name of office
Brooksville FL 34613 Hernando
City Zip Code County
Deborah J. Parker RN OCN
Name of Physician or Licensee Reporting

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

Patient's address for Physician or Licensee Reporting
FLORIDA CANCER INSTITUTE, P.A.
11307 CORTEZ BLVD.
BROOKSVILLE, FL 34613
(954) 599-1926 FAX (954) 597-2154

II. PATIENT INFORMATION

[Redacted]
Metastatic Squamous Cell Carcinoma
Diagnosis of Parotid with left cervical nodal involvement

[Redacted]
2/26/04
Date of Office Visit
Radiation Therapy
Purpose of Office Visit
518.81
ICD-9 Code for description of incident
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2/26/04 1:30 PM
Incident Date and Time

Location of Incident:
 Operating Rm
 Recovery Rm
 Other Radiation Therapy 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)

After radiation treatment, mask (head holder) was removed and patient was found to have no respiration + dusky color. CPR begun + EMS phoned immediately. Ambu + 100% O2 used to ventilate, but ventilations were very difficult due to large tumor mass @ neck + compromised airway. Myself and 2 RNs performed CPR for approx 5 min. until EMS arrived. After ventilation begun - pulse was checked + none found so chest compressions were begun at ratio of 5-1 ventilation. EMS then attempted endotracheal intubation unsuccessfully + transported to Oak Hill Hospital.

Pt died during XRay No - no surgical procedure

B) ICD-9-CM Codes

77413

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)

Clinac 6-100 Radiation Treatment Machine, Head-holder

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 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 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.

Pearl E Lawrence RT 040740 Larry Gandle MD ME 00518
Deborah J Parker RN OCN RN 2943092
John Brodtman RN
Bobby Joseph RN

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)

Natural Death occurred at time of radiation treatment

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

none

V.

Deborah J Parker RN OCN RN 2943092
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
2/26/04 5:30 pm
 DATE REPORT COMPLETED TIME REPORT COMPLETED

office closed Columbia hosp
NOT ready re Columbia

No AAAHC
accreditation
NO accreditation

STATE OF FLORIDA
Job Bank, Supervisor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FROM TO:
Department of Health, Consumer Services Unit
4882 Bald Cypress Way, Bin C78
Tallahassee, Florida 32309-3275

276
220



⊕ Certs final Plastic Surgery
American Board of Surgery
lost 8/15/04
842-6141

305-553-0002

OFFICE INFORMATION

Florida Center for Cosmetic Surgery - WFB
West Palm Bcn 33406 Palm Beach
Flanagan, MD

1501 Forest Hill Blvd
(561) 964-0001
Registration # 242

II. PATIENT INFORMATION

[Redacted patient information]

[Redacted patient information]

hypertension - pneumothorax
note - listed on informed consent

2/2/04
Breast augmentation
ICD-9 Code for description of incident
J96
Date of Surgery (s) or (s)

III. INCIDENT INFORMATION

2/2/04 approx 12:30pm

Location of Incident:
 Operating Room
 Recovery Room
 Other

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

A) Describe circumstances of the incident (narrative)
(Use additional pages as necessary for complete response)

During breast augmentation surgery, bilateral pleura were
"nicked". Pleura were repaired intra-operatively by the
surgeon. Pt taken to Columbia Hospital post-operatively
to receive a CXR and overnight observation. Pt was
discharged on 2/25/04 in stable condition and is
recovering according to expected course. No further
complications.

breast Aug -> biled pneumo -> ground and analgesic -> to hosp. -> no results

MAR-08-2004 MON 05:52 PM FLORIDA CENTER

FAX NO. 5619640104

P. 02

03/08/2004 18:18 FAX 561 988 0658

UNIVERSAL HEALTHCARE INC

003

B) ICD-9-CM Codes

88.5 Breast Aug
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 81-88.9)

E879.9
Accident, event, circumstances, or specific agent that caused the injury or event (ICD-9 E-Code)

860 Pneumothorax - repaired
Resulting Injury (ICD-9 Codes 800-899.9)

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

D) Outcome of Incident (Please check)

non-emergency hospital admission for observation

- 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

- 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

Outcome of transfer - e.g., death, brain damage, observation only
Name of facility to which patient was transferred

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

F. Janssen MD ME 86345
A. V. P. H. S. in MD (anesthesiologist) ME 48681
E. M. H. H. A
J. Stranberg RN

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 (see comment above as necessary for complete response)

This patient with very thin intercostal spaces incisions were too small for adequate visualization. No damage to lungs. Repair successful.

B) Describe corrective or preventive action(s) taken (see comment above as necessary for complete response)

Would change to a transaxillary incision in patients with small nipples, in order to provide a better visualization of tubes.

V. Janssen ME 86345
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

DATE REPORT COMPLETED TIME REPORT COMPLETED

08/17/02 08:57 FAX 9225036

277

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P. 3

BD OF MED PL

STATE OF FLORIDA
Jeb Bush, Governor

*Gastro Intestinal 02
no board certification
Not accredited*

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14900,
Tallahassee, Florida 32317-4900



I. OFFICE INFORMATION
GASTROINTESTINAL DIAGNOSTIC CENTERS

Name of office
PEMBROKE PINES, 33024 broward
City Zip Code County
NORA KELLY RN
Name of Physician or Licensee Reporting
Patient's address for Physician or Licensee Reporting

2245 N. UNIVERSITY DR
Street Address
954-963-0888
Telephone
74588-2 175
License Number & office registration number, if applicable

II. PATIENT INFORMATION



Age APRIL 30, 2003 Gender Medical/Medicare
Date of Office Visit
Purpose of Office Visit CONSULTATION
ICD-9 Code for description of incident 211.3
Level of Surgery (R) or (H) level II

Diagnosis
FAMILY HISTORY OF COLON CANCER

III. INCIDENT INFORMATION

JUNE 3, 2003
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other gi suite room 1

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 performed colon cleansing prep at home using fleets phospho soda. [redacted] was prepped for colonoscopy and sedated with Demerol 75 mg and Versed 6 mg in divided doses. Polypectomies were performed at transverse colon, hepatic flexure, proximal and distal ascending colon and rectum. Total procedure time was 30 minutes. Patient was recovered and discharged in good condition without complaints with a friend. Patient called service at 8 pm c/o abdominal pain. Per Dr. Youseff, patient was instructed to seek medical attention at Memorial Hospital Pembroke ER which [redacted] did. Abdominal Xray was negative but patient had a rigid abdomen. Surgical consultation was obtained and patient was taken to OR. A perforation of transverse colon was surgically repaired.

The patient tolerated the surgery well and recovered post operatively without difficulty and discharged to home in good condition.

Let any equipment used if directly involved in the incident... hot biopsy forceps snare

- Surgical procedure performed on the wrong site
- Wrong surgical procedure performed
- Surgical repair of injuries or damage from a planned surgical procedure
- If transfused to
 - Death
 - Brain Damage
 - Spinal Damage
 - Permanent and irreversible loss of function of limb(s) or joint
 - Fracture or dislocation of limb(s) or joint
 - Loss of consciousness, prolonged, or sensory function
 - Any condition that required the transfer of the patient

List all providers, including those involved if they are providing information, and the capacity in which they were directly involved with the incident.

Dr. Yotseff, M.D. License # 0072171 physician performing...
Dr. Kelly, M.D. License # 74500 performing sedation...
2245 N. Hawthorn Drive
P.O. Box 1000 Ft. Collins CO 80504

ANALYSIS AND CORRECTIVE ACTION
Primary (direct cause) of this incident...
Secondary (contributing) causes...
Corrective action...
Date of completion of corrective action...
Signature of provider...
Signature of supervisor...
Signature of informed...
Date of completion of corrective action...

05 2003 2:32PM GASTROINTEBIRGCTR

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P. 5

17/02 05:57 FAX 0221036

39 OF MED FL

003

B) ICD-9-CM Codes

211.3	45385	569.83
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-89.9)	Accident, event, circumstances, or specific agent that caused the injury or event (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident
 (Use additional sheets as necessary for complete response)
 Olympus CF 100 colonoscope, hot biopsy forcep, snare

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 checked="" 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 outcome of the patient to a licensed hospital	<input type="checkbox"/> Brain Damage
Outcome of transfer - e.g., death, brain damage, observation only	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred	<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.

Peter Yotseff, M.D. License # MS0072171 physician performing procedure

Nora Kelly, R.N. License # 74588-2 performing conscious sedation, pt monitoring

Med James GI Tech assisted M.D. w/ biopsies

2245 N. University Drive
Pembroke Pines FL 33024

List witnesses, including license numbers if licensed, and locating information if not listed above
Name as above

ANALYSIS AND CORRECTIVE ACTION

Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)
multiple colon polyp removal performed

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

Listed as potential complication of procedure on informed consent form

[Handwritten Signature]

SIGNATURE OF PHYSICIAN LICENSEE SUBMITTING REPORT

ME 0072171
LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

STATE OF FLORIDA
Job 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



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I. OFFICE INFORMATION

Cancer Centers of Florida
Name of office

Orlando 32806 Orange
City Zip Code County

Stacy Fogg-Smith
Name of Physician or Licensee Reporting

Same as above
Locating Information for Physician or Licensee Reporting

52 West Gore Street
Street Address

(407) 426-8484
Telephone

BN 3023152
License Number

NO patient

II. PATIENT INFORMATION



115103
Patient Identification Number

Anal/Rectal Cancer
Diagnosis



11/5/03
Date of Office Visit

Radiation Therapy
Purpose of Office Visit

154.2
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

11/5/03 at 1:30pm
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other: no office

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

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

Dr. Michael Swartz approached me to assist him with a patient in the exam room while at lunch. When I arrived in room, patient was complaining of chest tightness/pain. vital signs taken and stable. Heart rate was noted by Dr. Swartz as irregular. Pt stated that [redacted] had history of CABG & atrial fibrillation. Patient asked if [redacted] had anyone able to transport [redacted] to ER. Pt stated no. That [redacted] drove [redacted]. When asked how long pain has been bothering [redacted] at this point, [redacted] stated over 10 minutes. I called 911 per doctors orders. Patient evaluated by EMT & transpo via ambulance to Orlando Regional.

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03 DEC 10 PM 2:41

B) ICD-9-CM Codes N/A

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

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

Resulting injury (ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

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

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

① Dr. Michael Swartz was doctor in office at time of situation. given first to patient at time of complaints
② Stacy Foggs Smith - approached by MD to assist after pt stated complaints

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

N/A

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

Dr Swartz - ME 78489

v.

Stacy 810
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

RN3023152
LICENSE NUMBER

11/6/03
DATE REPORT COMPLETED

3:00pm
TIME REPORT COMPLETED

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PRAES Production (MQ-P)

01/22/04
09:17:49

etnrbal12/2.16 MAINTAIN ANY LICENSE DATA 1501/MED-ME

@File: 74225

@SSN: ██████████ Medical Doctor

@Lic: 78489 CLEAR,ACTIVE

@Name: DR. MICHAEL STEPHEN SCHWARTZ (DBA:0 Old:1)

@Addr: CANCER CENTERS OF FLORIDA State: FL

@ 52 WEST GORE ST Zip: 32806

@City: ORLANDO County: ORANGE

@

@Certificate No: 59901 First License: 07/09/1999

@ " Date: 11/20/2001 In Rank Since: 07/09/1999

@Last Renewal: 11/19/2001 License Method: 1021,INITIAL,ENDORSE

@Current Expiry: 01/31/2005 Renewal Notice: 10/23/2001

@ In Directory? N Include

@Status Date: 07/09/1999 Fee Exempt? N

@Note: 4/99 board approved

@

@

@Query: ... O-Lics_Supported P-Exam_Hist R-Cert_Log S-Change_Log ...

@ Display licenses supported by selected license

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PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14900,
Tallahassee, Florida 32317-4900

OFFICE INFORMATION
Cancer Centers of Florida
Orlando
3200
Orange
Mary Ellen Smith
Director of Cancer Programs

52 West Gore Street
Orlando, FL 32806
RA 3023152

iHEADER State as above PRAES Production (MQ-P) 01/22/04
coliver 09:17:58

etnrbal31/2.2 DISPLAY SUBORDINATE LICENSES 1501/MED-ME#####

o SUPERIOR o
o File: 74225 o
o SSN: [REDACTED] Medical Doctor o
o Lic: 78489 CLEAR, ACTIVE o
o Name: DR. MICHAEL STEPHEN SCHWARTZ o
o Addr: CANCER CENTERS OF FLORIDA State: FL o
o Zip: 32806 o
o City: ORLANDO County: ORANGE o

o i# RelationID Rank Status Act Status Count Max Item 1 of 20 o
o 010 ALTER-SUP RS OBLIGATIONS ACTIVE 0 o
o 020 MED DIR HCCR CLEAR ACTIVE 0 5 o
o 030 ME LICENSE LL DELINQUENT 0 o
o 040 OSR OSR OBLIGATIONS ACTIVE 0 o
o i# o
oAction: Select List Exit o
o Select supporting license o
#####

1 Sess-1 167.78.1.20 1 22/9

The event occurred on 1/18/04. I arrived in room. Patient was complaining of chest pain (pain 10/10) signs taken and stable. Heart rate was noted by Dr. Swartz as irregular. At stated that [REDACTED] had history of CAD & atrial fibrillation. Patient asked if [REDACTED] also had heart pain. At stated no. That [REDACTED] was asked how long pain has been happening. At stated pain started over 10 minutes. I called 911 per doctors orders. Patient evaluated by EMT & transported to Orlando Regional.

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