

B) ICD-9-CM Codes

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

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

786.09  
Resulting injury  
(ICD-9 Codes 800-999.9)

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

NIA

D) Outcome of Incident (Please check)

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

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

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

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

NIA

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

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

None needed.

Katharina Low

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

ARNP 3396982 FL  
LICENSE NUMBER

10/9/02  
DATE REPORT COMPLETED

1510  
TIME REPORT COMPLETED

GMW 10/2/02

ST procedure  
ST elevation  
after hand wash

206



STATE OF FLORIDA  
Jeb Bush, Governor

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

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

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

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

II. PATIENT INFORMATION

[Redacted]  
Patient Identification Number  
CHD MI  
Diagnosis

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

III. INCIDENT INFORMATION

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

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Nuclear Med

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

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

Completed treadmill. During recovery phase of stress test physician noted ST elevation. IVty drip hung at 5mg IV. D222 NC initiated. Ems called. To cath lab via EMS at LPMC.

B) ICD-9-CM Codes

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

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

4139  
Resulting injury (ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a licensed hospital	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure <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
---	--

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

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

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

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

To hospital via ambulance

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

STATE OF FLORIDA  
Jeb Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

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

*no process  
Sizemore  
Chow*



RECEIVED  
02 NOV -5 AM

*NOT RELEVANT*

207

I. OFFICE INFORMATION

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

52 W Gore St  
Street Address  
4074268484  
Telephone  
License Number

II. PATIENT INFORMATION

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

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

III. INCIDENT INFORMATION

10-22-02 1050 AM  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other office

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

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

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

B) ICD-9-CM Codes

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

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

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

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

O2, NS 500cc

D) Outcome of Incident (Please check)

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

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

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

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

[Redacted]

IV. ANALYSIS AND CORRECTIVE ACTION

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

N/A

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

N/A

V.

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

*Pulmonary  
hemorrhage during  
heart catheterization  
no response*

*209*

**208**

[Redacted]

STATE OF FLORIDA  
Jeb Bush, Governor



**PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT**

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

RECEIVED  
CONSUMER SERVICES UNIT  
NOV 14 AM 7:50

*Yes, only Heart Cath  
Board cert, yes American  
Board  
Hosp priv  
AGH  
Hosp*

**I. OFFICE INFORMATION**

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

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

**II. PATIENT INFORMATION**

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

**III. INCIDENT INFORMATION**

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

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

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

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

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

93526	417.8, 416.0	786.3, 518.82
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

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

(Use additional sheets as necessary for complete response)  
#7 French Swan Ganz Double lumen monitoring catheter, #7 french pinnacle sheath

**D) Outcome of Incident (Please check)**

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

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

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

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

Kim Giberti RN 2750592

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

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

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

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 38483

LICENSE NUMBER

11/2/02

DATE REPORT COMPLETED

16<sup>45</sup>

TIME REPORT COMPLETED

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

(Dugan J. Bahwin RN 2508252)

This report was prepared by myself and  
Steven Roach MD.



209



~~208~~ 210



STATE OF FLORIDA  
Jeb Bush, Governor

RECEIVED  
CONSUMER SERVICES UNIT

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

02 DEC -3 AM 7:45

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

no procedure  
migraine -> syncope ->  
muscle.

NA

I. OFFICE INFORMATION

Name of office Watson Clinic (Main) Urgent Care  
1100 Lakeland Hills Blvd.  
City Lakeland Fl. Zip Code 33805 County Polk  
Name of Physician or Licensee Reporting Debbie Howard RN  
Patient's address for Physician or Licensee Reporting 1100 Lakeland Hills Blvd.

Street Address 1100 Lakeland Hills Blvd.  
Telephone (863) 680-7000  
RN 1467312  
License Number & office registration number, if applicable

II. PATIENT INFORMATION

Pat [Redacted]  
Pa [Redacted]  
Patient Identification Number 346.11  
Diagnosis

Age 11-15-02 Gender [Redacted] Medicaid Medicare  
Date of Office Visit  
Purpose of Office Visit Migraine headache + bruising behind ear  
ICD-9 Code for description of incident 780.2  
Level of Surgery (II) or (III) NA

III. INCIDENT INFORMATION

Incident Date and Time 11-15-02 12:00 pm

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other waiting room

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

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

Pt. presented to urgent care with complaint of migraine starting 11/9/02 and bruising behind (C) ear without known accident. Given Demerol 75mg + Phenergan 25mg IM. Sent to CT for CT of head. While awaiting results pt syncope in chair. Transferred to Lakeland regional medical center via ambulance after initial treatment in urgent care. CT scan was without contrast and result did show an old subdural hematoma.

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

346.11

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

J21750 / J2550

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

780.2

Resulting Injury  
(ICD-9 Codes 800-999.9)

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

**D) Outcome of Incident** (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> 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>Lakeview Regional Medical Center</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.**

Dr. Guitano MD 0051774      Kevin Harvey, MD  
Crista Clark RN - RN 2001692      Ellen Bowler RN - RN 2969902  
Ingrid Howell RN (1467312)  
Wendy Dyle LPN PN 1359941

**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)

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

None indicated

Joseph M. Huxell RN  
**SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT**  
11-19-02  
**DATE REPORT COMPLETED**

RN 1467312  
**LICENSE NUMBER**

11:50 AM  
**TIME REPORT COMPLETED**

no procedure  
bleed, low  
procedures

NA  
209  
210



### Florida Medical Association

PO Box 10269 • Tallahassee, FL • 32302 • 123 S. Adams St. • 32301  
850.224.6496 • 850.224.6627 (fax) • Internet Address: www.fmaonline.org

RECEIVED  
CONSUMER SERVICES UNIT  
02 DEC -3 AM 7:43

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

#### OFFICE INFORMATION

Name of office Vascular Access Center of Orlando

Street Address 1511 Sligh Blvd. Suite A

City Orlando, FL

Zip Code 32806

County Orange

Telephone (407) 851-5600 ext. 190

Name of Physician or Licensee Reporting Jorge Larranaga, M.D.

License Number ME 0070052

Locating Information for Physician or Licensee Reporting Mike Lowman

#### PATIENT INFORMATION

Patient Name

Age 41

Gender

Medicaid

Medicare

LOCATING INFORMATION

Date of Office Visit Nov 1, 2002

Patient Identification Number N/A

Purpose of Office Visit Malfunctioning Perm. Cath

Diagnosis ESRD

ICD-9 Code for Diagnosis \_\_\_\_\_

INCIDENT INFORMATION

Location of Incident: Vascular Access Center of Orlando

Incident Date and Time Nov. 1, 2002 / 0905AM

\_\_\_\_\_ Operating Rm

\_\_\_\_\_ Recovery Rm

Other vascular Access Center waiting room.

Note: If the incident involved a death, was the medical examiner notified?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

Was an autopsy performed?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

Describe circumstances of the incident (narrative)

see attached

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(use additional sheets as necessary for complete response)

B) ICD-9-CM Codes



Surgical, diagnostic, or treatment procedure of incident (ICD-9 Codes 01-99.9)  
**Physician Office Adverse Incident Report**  
**Vascular Access Center of Orlando**  
1511 Sligh Blvd. Suite A  
Orlando, Florida  
Accident, event, circumstances, or special cause of the injury or event. (ICD-9 E-Codes)

Nov. 1, 2002

Resulting injury (ICD-9 Codes 800-999.9)

Call was received from the dialysis center regarding patient with malfunctioning hemodialysis catheter. We were asked to see this patient and evaluate.

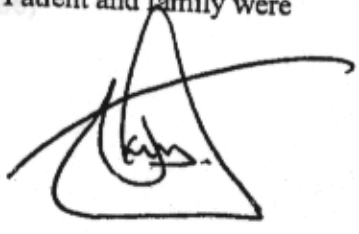
Patient arrived at the Vascular Access Center bleeding profusely from what appears to be a partially pulled catheter. Patient was immediately taken to the lab where pressure was held and the patient was cleaned. An assessment was made and the catheter was totally removed and pressure was held. Patient informed Dr. Larranaga that [redacted] is taking 7.5mg coumadin daily. After holding pressure for 1 hour and 10 minutes, the patient was still bleeding. At this time we called 911 to transport the patient to the hospital where the patient can be monitored and a new catheter placed for dialysis. The patient was hemodynamically stable throughout this period of time. Patient and family were informed throughout the process

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



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

N/A  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(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. Jorge Larranaga

Mike Lowman

Shannon Wood

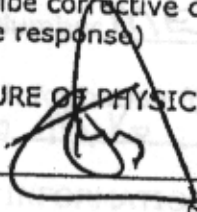
F) List witnesses, including license numbers if licensed, and locating information if not listed above

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)

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT



LICENSE NUMBER ME 0070052

DATE REPORT COMPLETED Nov 9, 2002

TIME REPORT COMPLETED 0830AM

# Physician Office Incident Report

CONSUMER SERVICES UNIT

02 DEC -14 AM 7:48

STATE OF FLORIDA  
~~Lawton Chiles, Governor~~

~~Jeb Bush~~

**CONFIDENTIAL**  
Risk Management  
CODE 15 REPORT

Agency for Health Care Administration  
Division of Health Quality Assurance  
Risk Management  
2727 Mahan Drive  
Tallahassee, FL 32308

Phone: (850) 487-1709; Fax: (850) 921-5459

YES AA Board Surgery  
AAAS F  
YES, Priv @ N. Florida Hos

Consumer Services Unit,  
P.O. Box 14000  
Tallahassee, FL.

32317-4000

*facial life  
- developed  
around fib after surgery*

Was a 24 Hour Report submitted for this incident?  Yes  No  
Date Submitted 11/27/02 (Attach Copy)

## I. FACILITY INFORMATION

John S. Poser, M.D.  
Name of Facility or Campus  
Gainesville Alachua  
City Zip Code County  
John Poser  
Person Reporting

780 S.W. 2nd Ave, #452  
Address  
(352) 372-3672  
Telephone  
M.D.  
Title

## II. PATIENT INFORMATION

[Redacted]  
Patient Name  
[Redacted]  
Patient Identification Number  
Atrial Fibrillation  
Admitting Diagnosis

[Redacted]  Medicaid  Medicare  
Age Sex  
11/20/02  
Date of Admission  
427.31  
ICD-9 Code for Admit Diagnosis

## III. INCIDENT INFORMATION

11/20/01 A.M.  
Incident Date and Time

Location of Incident:  
 Emergency Rm  Radiology  
 Patient Rm  Outpatient Services  
 Operating Rm  Labor/Delivery  
 Recovery Rm  Other  
 Facility Campus

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

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

See attached - cardiologist cancelled again  
on the phone & provided [Redacted] cancel per  
home & then [Redacted] next day & of [Redacted] admit  
for compression [Redacted] wanted [Redacted]  
to stay over night



B) ICD-9-CM Codes

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

Asymptomatic Atrial fibr following surgery  
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)

Bovy

D) Outcome of Incident (Please Check)

- Death
- Brain Damage
- Spinal Damage
- Surgical procedure performed on the wrong patient
- Surgical procedure unrelated to the patient's diagnosis or medical needs
- Surgical procedure performed on wrong site
- Wrong surgical procedure performed
- Surgical procedure to remove foreign objects remaining from surgical procedures
- Surgical repair of injuries or damage from a planned surgical procedure

E) List license numbers of personnel and the capacity in which they were directly involved with this incident, i.e., ER physician, attending physician, surgeon, etc. (List social security numbers of unlicensed personnel)

John Poser, M.D. ME 41976 CEM

Brenda Mull - CE NA 146279-2

Heath Howell - 592-64-8743

April Wilson - 263-37-1082

Patti Hall, RN - 1549602

F) List license numbers of witnesses (List social security numbers of unlicensed personnel)

Same as above

IV. ANALYSIS AND CORRECTIVE ACTION

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

Pt had hx of Atrial fibrillation - cleared  
by M.D. cardiologist for  
have surgery

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

was careful monitoring during surgery

V. [Signature] M.D. 11/27/02  
Signature of Person Reporting Title Date



Member  
American Society of  
Plastic and Reconstructive  
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Specializing in  
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*John S. Poser, M.D., P.A., F.A.C.S.*  
Diplomate of the American Board of Plastic Surgery, Inc.

720 S.W. 2nd Avenue, Suite 452  
Gainesville, Florida 32601  
Telephone (352) 372-3672  
Fax (352) 378-1117

November 20, 2002

State of Florida

To Whom It May Concern:

██████████ is a healthy ████████ year old ████████ who underwent facelift surgery on 11/20/02. The patient had a history of atrial fib. under good control and saw a cardiologist for consultation prior to facelift surgery. Following surgery the patient did develop asymptomatic atrial fib. and was transferred to the hospital for observation and review by ████████ cardiologist.

Sincerely,

*John S. Poser, M.D.*

JSP/sem

1. Was the incident reported to you by the medical staff?  Yes  No

2. In your opinion, was the incident preventable?  Yes  No

3. In your opinion, were the circumstances of the incident preventable?  Yes  No

*See attached - incident report - successful outcome*

No procedure  
3 weeks post-op  
post of (after  
TUM in hospital)  
bleed in waiting room

212

STATE OF FLORIDA  
Jeb Bush, Governor



RECEIVED  
CONSUMER SERVICES UNIT  
02 DEC 11 AM 7:43

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

JUST LADIES HEALTHCARE  
Name of office  
FT PIERCE 34950 STUCIE  
City Zip Code County  
LEIGHT B. HOPPE M.D.  
Name of Physician or Licensee Reporting

1304 N. LANNWOOD CIRCLE  
Street Address  
772 489 6636  
Telephone  
ME 79129  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age 11/21/82  
Gender  
Medicaid Medicare

Date of Office Visit  
Purpose of Office Visit post of follow up.

Diagnosis post of vaginal cuff bleeding

ICD-9 Code for description of incident 997.5  
Level of Surgery (II) of (III) 623.8

III. INCIDENT INFORMATION

11/21/2002 10:30 a.m.  
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 N/A.

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

uncomplicated TVH Anterior & posterior colporrhaphy done 10/29/02. Patient presented for post of visit had URI symptoms, elevated blood pressure, began bleeding in the waiting room. Evaluation showed arterial bleeding at cuff - unable to control in the office - taken to the OR for suturing.

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9) <u>N/A</u>	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes) <u>E879.8</u>	Resulting injury (ICD-9 Codes 800-999.9) <u>998.11</u>
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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 <u>OR admission</u> Name of facility to which patient was transferred <u>LAWNWOOD REGIONAL MEDICAL CENTER</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.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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)

Suture at the top of the vagina broke & dissolved 3 weeks post op.

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

under adequate anesthesia the vaginal cuff was visualized and suture material was used to control arterial bleeding.

v. 10/10/02 ME 79129  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
12/3/2002 1645  
 DATE REPORT COMPLETED TIME REPORT COMPLETED