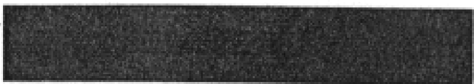
no procedure
wound dehiscence after
staple removal

N/A

213



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
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02 DEC 18 AM 7:39

# PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

## I. OFFICE INFORMATION

Southeastern Urological Center PA
Name of office

2000 Centre Pointe Blvd
Street Address

Tallahassee 32308 Leon
City Zip Code County

850-201-0406
Telephone

James C. Springer MD
Name of Physician or Licensee Reporting

ME 0056136
License Number & office registration number, if applicable

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

## II. PATIENT INFORMATION

Age Gender ☐ Medicaid ☐ Medicare

11-27-02
Date of Office Visit

Patient Identification Number

Staple removal post op
Purpose of Office Visit

Prostate Cancer
Diagnosis

998.3
ICD-9 Code for description of incident

NA
Level of Surgery (II) or (III)

## III. INCIDENT INFORMATION

11-27-02
Incident Date and Time

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☑ Other Drs Office

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

### A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Patient came to office for staple removal after prostatectomy. Wound was steri stripped after staples removed and patient discharged. Later the same afternoon the patient returned to the office with a wound dehiscence and was transported to TMH for admission to the hospital for subsequent surgical repair via ambulance.

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

### B) ICD-9-CM Codes

| NA | 40.3 , 60.5 | 998.3 |
|---|---|---|
| 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 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: Tallahassee Memorial

- ☐ 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.

Diane Glynn RN RN 11 41942
James C Springer MD ME 0056136
Joseph L. Campo MD ME 57214

### 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)

Incision should have been healed within this time frame.

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

Patient appropriately transferred to hospital for further treatment and evaluation.

**V.** Terry Spearls RN for James C Springer MD 91591 | ME 0056136

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — LICENSE NUMBER

12-06-02 — 1813?

DATE REPORT COMPLETED — TIME REPORT COMPLETED

214

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED CONSUMER SERVICES UNIT 03 JAN 21 AM 7:26

# PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

Board cert, accredited by, Hosp. privileges

IV fentanyl by operator, ano- near aspiration, no sequelae

BOARD CERT YES surgeon, ACCREDITED, YES AAAHC, HOSP. PRIV INTERVENTION PAIN BAY, PAIN ONLY

## I. OFFICE INFORMATION

the Back Center at Brevard Orthopaedic
Name of office

315 E NASA Blvd
Street Address

Melbourne | 32934 | Brevard
City | Zip Code | County

321 723 7716
Telephone

Dr NANCY LAYTON
Name of Physician or Licensee Reporting

ME # 0051048
License Number

315 E NASA BLVD. Melbourne 32934
Locating Information for Physician or Licensee Reporting

Board certified, yes Non-surgery
which, Anesth. sub-special
office accredited, yes
which, AAAHC
Hosp. priv; spec. intervention pain mgm. PALM BAY

## II. PATIENT INFORMATION

Age

12/11/02
Date of Office Visit

radio frequency
Purpose of Office Visit

Patient Identification Number

Neck pain.
Diagnosis

ICD-9 Code for Diagnosis

## III. INCIDENT INFORMATION

12/11/02 945/am
Incident Date and Time

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☒ Other procedure 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 vomited just after completion of C-3 RFTC (radiofrequency thermocoagulation), with transient hypoxia. Pt. resusciated with Narcan, oral airway, 100% NRB mask. Paramedics called + pt transported to HRMC ER to evaluate for ASPIRATION. VS UPON D/C FROM our clinic were stable on R.A. R.A $Sa0_2$ 93%


Form # DH-MQA 1030, 2/00

B) ICD-9-CM Codes

| 723.8 | 787.03 ~~518.81~~ | 518.81 |
|---|---|---|
| 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)

None

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

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

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

Maureen Vouglus 1855 Hammock Estates Ln Melbourne FL 32934 RN 2069822
Joann Fernico 2989 Park Village Way Melbourne FL. 32935 R.T.-072095
Barbara Cantillon RN 1673802; 419 Ocean Ave #401; Melbourne Bch 32951
Nancy L.R. Layton, MD, treating physician ME 051048, 315 E. NASA BLVD, Melbourne FLORIDA 32901

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)

Nausea due to IV Fentanyl lead to ~~near~~ emesis and near aspiration causing transient glottic spasm and transient hypoxemia

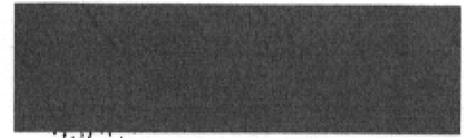
B) **Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response)

Immediately stopped procedure and began ACLS protocol. patient responded to treatment initiated. Post episode exam by myself and ER staff showed no sequelae

V. [signature]

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — ME 051048 LICENSE NUMBER

12/11/02 DATE REPORT COMPLETED — 12:38 TIME REPORT COMPLETED



no procedure allergic reaction → cannot

N/A

215

03 JAN 21 AM 7:21

CONSUMER SERVICES UNIT

**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


**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. Ste. 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 0070052

Locating Information for Physician or Licensee Reporting Mike Lowman

PATIENT INFORMATION

Patient Name

Age

Gender

Medicaid

Medicare

6/9/00

**LOCATING INFORMATION**

Date of Office Visit Jan. 7, 2003

Patient Identification Number [redacted]

Purpose of Office Visit Thrombosed A-V graft

Diagnosis Clotted Access

ICD-9 Code for Diagnosis 36831; 35476; 35475; 75978; 75790

**INCIDENT INFORMATION**

Location of Incident: Vascular Access Center Recovery Room

Incident Date and Time Jan. 7, 2003 1037

_____ Operating Rm

X Recovery Rm

_____ Other

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)

Patient had an allergic reaction to the contrast media. No Hx before and four previous procedures without incidence. Reaction occured post procedure and was treated with 50mg benadryl and 125mg Solumedrol. Patient was monitored and transferred to dialysis for treatment. Patient was discharged from dialysis center, following 2 hr. treatment, without incident.

(use additional sheets as necessary for complete response)

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

Omnipaque contrast media

(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

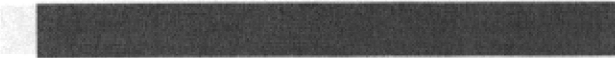
** if it resulted in

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.

Jorge Larranaga M.D. 007005[illegible]

Sharon Wood LPN PN1296781

Mike Lowman CVT

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

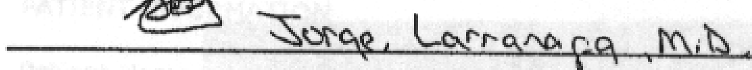
Mike Lowman

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

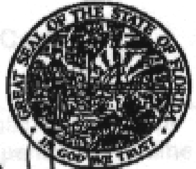


Jorge Larranaga M.D.

LICENSE NUMBER 007005[illegible]

DATE REPORT COMPLETED Jan 8, 2003

TIME REPORT COMPLETED 0800



216

no proof
Chemo not known

RECEIVED
CONSUMER SERVICES
03 JAN 24 AM 7:

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: GIFFEN CANCER CENTER
Street Address: 981 37TH PLACE
City: VERO BEACH
Zip Code: 32960
County: INDIAN RIVER
Telephone: 772-770-5800
Name of Physician or Licensee Reporting: JOHNSON SMITH RN OCN
License Number: 2199512 FL
Locating Information for Physician or Licensee Reporting:

## II. PATIENT INFORMATION

Age / Gender / Medicaid / Medicare
Locating Information
Date of Office Visit: 12/23/02
Patient Identification Number
Purpose of Office Visit: Chemotherapy
Diagnosis: CLL
ICD-9 Code for Diagnosis:

## III. INCIDENT INFORMATION

Incident Date and Time: 12/23/02 1030 AM

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☑ Other: Chemotherapy room

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

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

Pt returned from Bathroom quite unsteady, skin grey. Appears to have had an syncope episode. Breathing stopped. Unable to palpate heart beat. Pt resuscitated and transported via EMS to IRMH.


Form #

## 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.

June Goodrich, RN
Jeannine Smith RN, OCN
Andy Fender PA-C
AO Bo. leau

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

## IV. ANALYSIS AND CORRECTIVE ACTION

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

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

## V.

[signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 51697
LICENSE NUMBER

12/23/02
DATE REPORT COMPLETED

1030
TIME REPORT COMPLETED

217

no procedure
vasovagal, syncope
after blood draw

NOT RELEVANT

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

WATSON CLINIC LLP SOUTH LABORATORY
Name of office

1033 N. PARKWAY FRONTAGE RD.
Street Address

LAKELAND FL. 33803 POLK
City Zip Code County

863-647-8011
Telephone

Name of Physician or Licensee Reporting

LABORATORY L800001553
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

## II. PATIENT INFORMATION

Age Gender Medicaid Medicare

1/6/03 - LABORATORY
Date of Office Visit

Patient Identification Number

BLOOD DRAW
Purpose of Office Visit

SYNCOPE
Diagnosis

780.2
ICD-9 Code for description of incident

NONE
Level of Surgery (II) or (III)

## III. INCIDENT INFORMATION

1/6/03 9:08 AM
Incident Date and Time

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

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)

AS WAS LEAVING THE LABORATORY DRAW ROOM BECAME DIZZY AND PASSED OUT. FALL WAS HEARD BY LPN KELLY LUPOLD- WHO FOUND ON FLOOR UNRESPONSIVE. SHE FELT AIRWAY WAS PARTIALLY OBSTRUCTED SO SHE LIFTED CHIN TO OPEN AIRWAY. AFTER APPROX. 1 1/2 MINUTES, SPONTANEOUSLY OPEN EYES AND SAID FELT LIGHTHEADED AND DIZZY. WAS ASSISTED TO A WHEELCHAIR AWAITING TRANSPORT TO EMERGENCY ROOM. DID HAVE SOME NAUSEA AND VOMITING RIGHT BEFORE WAS TAKEN TO LRMC-ER


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

B) ICD-9-CM Codes Vaso vagal Syncope, 780.2

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

None

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

| | |
|---|---|
| ☐ Death<br>☐ Brain Damage<br>☐ Spinal Damage<br>☐ Surgical procedure performed on the wrong patient<br>☐ A procedure to remove unplanned foreign objects remaining from surgical procedure<br>☒ Any condition that required the transfer outcome of the patient to a licensed hospital<br>Outcome of transfer – e.g., death, brain damage, observation only<br>Name of facility to which patient was transferred Lakeland Regional Medical Center | ☐ Surgical procedure performed on the wrong site **<br>☐ Wrong surgical procedure performed **<br>☐ Surgical repair of injuries or damage from a planned surgical procedure<br>** if it resulted in<br>☐ Death<br>☐ Brain Damage<br>☐ Spinal Damage<br>☐ Permanent disfigurement not to include the incision scar<br>☐ Fracture or dislocation of bones or joints<br>☐ Limitation of neurological, physical, or sensory function;<br>☐ 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.**

Kelly Lupola LPN (FL PN1057891) assisted patient after [redacted] fell. Primary Care, Watson Clinic.
Rose Widener (FL RN 3214562) pt. assessment, assisted pt. to wheelchair. Adm Watson Clinic South.

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)

Not Preventable

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

V. [signature]
**SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT** FL. RN 0995362 **LICENSE NUMBER**

7/16/03 **DATE REPORT COMPLETED** 8:40 AM **TIME REPORT COMPLETED**


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

218

no procedure
Chemo Rx

Not Relevant

STATE OF FLORIDA
Jeb Bush, Governor

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03 JAN 28 AM 7:14

# PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

## I. OFFICE INFORMATION

Name of office: Florida Cancer Institute
Street Address: 11307 Cortez Blvd.
City: Brooksville Zip Code: 34613 County: Hernando
Telephone: 352-596-1926
Name of Physician or Licensee Reporting: Michele Eger RN
License Number & office registration number, if applicable: 2628182
Patient's address for Physician or Licensee Reporting:

## II. PATIENT INFORMATION

Age Gender Medicaid Medicare
Date of Office Visit: 1/13/03
Patient Identification Number
Purpose of Office Visit: Chemotherapy
Diagnosis: Nonsmall cell lung cancer
ICD-9 Code for description of incident: 427.5
Level of Surgery (II) or (III)

## III. INCIDENT INFORMATION

Incident Date and Time: January 13, 2003 time: 3:10 pm

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☑ Other Chemotherapy room

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

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

Pt received chemotherapy, tolerated Taxotere s̄ difficulty. Approx. 5 min into Carboplatin pt began coughing and appeared to be choking prior to respiratory arrest. Pt removed via recliner chair to hallway and placed on floor. Pt without pulse or respirations at this time. CPR initiated. One ampule of Epinephrine given IVP at 3:13 pm, one amp of Na bicarb given IVP at 3:15 - both per physician orders. At 3:15 pm pt had a pulse and started breathing on [redacted] own. 3:20 pm pt transported via EMS to Oak Hill Hospital ER.


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

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

| V58.1/162.8 | 427.5 | 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)

- ☐ 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 Oak Hill 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

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

Michele Eger RN-administered Epi + Na bicarb
Sharon Robitille RN-CPR 3176322
John Brodtmon RN-CPR 227275

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

See above

## IV. ANALYSIS AND CORRECTIVE ACTION

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

Possible reaction to Carboplatin

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

Carboplatin D/C for this patient. Pt sent via EMS to Oak Hill Hospital

**V.** Michele Eger RN — 2628182

**SIGNATURE OF ~~PHYSICIAN/~~LICENSEE SUBMITTING REPORT** — **LICENSE NUMBER**

1-13-03 — 5pm

**DATE REPORT COMPLETED** — **TIME REPORT COMPLETED**

219

STATE OF FLORIDA
Jeb Bush, Governor

CONSUMER SERVICES UNIT
03 JAN 30 AM 7:10

# 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 procedure
atrial fib noted on admit
treated
N/A

## I. OFFICE INFORMATION

the BACK Center at Brevard Orthopaedic.
Name of office

315 E NASA BLVD
Street Address

Melbourne | 32901 | Brevard
City | Zip Code | County

321-723 7716
Telephone

Dr Nancy LAYTON.
Name of Physician or Licensee Reporting*

ME 005 1048
License Number

SAME
Locating Information for Physician or Licensee Reporting

## II. PATIENT INFORMATION

Patient Identification Number

Age | Gender | Medicaid | Medicare

1-10-03
Date of Office Visit

Lumbar epidural injection.
Purpose of Office Visit

BACK PAIN
Diagnosis

724.2.
ICD-9 Code for Diagnosis

## III. INCIDENT INFORMATION

1/10/03 9AM
Incident Date and Time

Location of Incident:
☐ Operating Rm ☐ Recovery Rm
☒ Other Procedure 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)

In preop area, pt noted to have HR = 72, regular pulse
pt ambulated 25 feet to procedure area placed prone
and monitors showed atrial fibrillation with
RATE ≥ 160.
procedure nor anesthesia had begun. No procedure
call for transport to ER initiated.
labetolol 10mg IV ÷ given & $O_2$ 2 lpm NC.
When HR ~90 bpm, lumbar epidural steroids
placed for pt's history of severe pain and
severe spinal stenosis.


Form # DH-MQA 1030, 2/00

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B) ICD-9-CM Codes

Not yet initiated

| 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)

None

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

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

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

Dr NANCY LAYTON 315 E NASA BLVD Melbourne FL 32901 ME0051048
MAureen Vouglas - 1855 Hammock Estates Ln Melbourne FL 32934 RN 2069822
Mia Fernico - 989 Park Village Way Melb. Fl. 32935 R.T. 1199

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

SAme

## IV. ANALYSIS AND CORRECTIVE ACTION

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

① patient had had recent, relatively prolonged hospitalization for non-cardiac causes.
② H/o Mitral valve prolapse

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

① Call to transport for ASAP/STAT transfer to ER
② Labetalol IV + Oxygen to control heart rate

V. [signature]

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — ME051048 LICENSE NUMBER

1/10/03
DATE REPORT COMPLETED

1703
TIME REPORT COMPLETED


Form # DH-MQA 1030, 2/00

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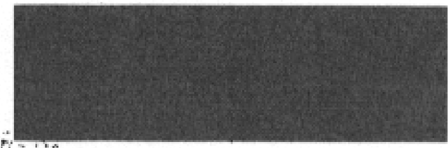

Chemo Pt
no Precedent

Not relevant

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
03 JAN ... AM 7:29

# PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

## I. OFFICE INFORMATION

Name of office: Space Coast Medical Assoc.

Street Address: 225 Cone Rd.

City: Merritt Island FL | Zip Code: 32952 | County: Brevard

Telephone: (321) 453-1361

Name of Physician or Licensee Reporting: DR. Richard Levine

License Number: 40927

Locating Information for Physician or Licensee Reporting:

## II. PATIENT INFORMATION

Age | Gender | ☐ Medicaid ☐ Medicare

Date of Office Visit: 1/15/03

Purpose of Office Visit: Routine office visit & chemotherapy

Diagnosis: Lung Cancer

ICD-9 Code for Diagnosis: 162.0

## III. INCIDENT INFORMATION

Incident Date and Time: 1/15/03

Location of Incident: ☐ Operating Rm ☐ Recovery Rm ☒ Other: Chemo rm

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

### A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

1:30. Pt unresponsive, diaphoretic, Resp shallow, pink). Carboplatin stopped. Dr Levine present. IV NS KVO. O2 @ 2L NC. B/P 90/72 P60
1:32 IV restart (L) hand. Feet ↑ Ø response. sternal rub, 1:38 P64.
911 called. 1:40 Responded to sternal rub & name. Eyes open. BP 110/68 (A)
1:45 EMT here. HR reg rhythm (64) Pt responsive. Informed of transport to Wuesthoff hospital. Pt transported via ambulance to Wuesthoff hospital. [redacted] present.

1 of 2 pages
Form #

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)

IV hydration - O2

D) Outcome of Incident (Please check)

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

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

Mary Beth Rosser RN

Michelle Jahner RN

Edwin Hill RN

Dr. Richard Levine MD

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

V. [signature] MD

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

40977

LICENSE NUMBER

1/15/03

DATE REPORT COMPLETED

TIME REPORT COMPLETED

221

Contrast reaction
no procedure
N/A

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
02 FEB -5 AM 7:15

# PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

## I. OFFICE INFORMATION

Name of office: Tallahassee Diagnostic Imaging / Radiology Associates of Tallahassee

Street Address: 1623 Medical Dr.

City: Talla  Zip Code: 32308  County: Leon

Telephone: (850) 656-2261

Name of Physician or Licensee Reporting: Dr. Arjun Kaji, MD.

License Number: ME 76096

Locating Information for Physician or Licensee Reporting: 1541 Medical Dr. Talla, FL 32308

## II. PATIENT INFORMATION

Age  Gender  Medicaid  Medicare

Date of Office Visit: 01.28.03

Purpose of Office Visit: CTA (Head)

Patient Identification Number

Diagnosis: Syncope

ICD-9 Code for Diagnosis: 780.2

## III. INCIDENT INFORMATION

Incident Date and Time: 01.28.03  11 AM

Location of Incident:
☐ Operating Rm  ☐ Recovery Rm
☒ Other CT 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)

~~Attached~~ Adverse event possibly related to non-ionic iodinated contrast injection administered for CTA (Head) procedure.

1 of 2 pages
Form #