

STATE OF FLORIDA
Jeb Bush, Governor

220



RECEIVED
CONSUMER SERVICES UNIT
JAN 17 7:29 AM



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

Chew 20
Chew 4x

Not relevant

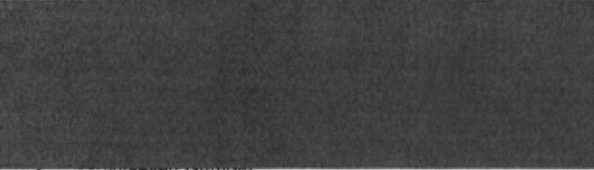
I. OFFICE INFORMATION

Name of office: Space Coast Medical Assoc.
City: Merritt Island FL 32952 Zip Code: Brevard County
Name of Physician or Licensee Reporting: DR. Richard Levine

Street Address: 225 CAVE RD.
Telephone: (321) 453-1361
License Number: 40927

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age: 11/5/03 Gender: [Redacted] Medicaid Medicare
Date of Office Visit: 1/15/03
Purpose of Office Visit: Routine office visit & chemotherapy
ICD-9 Code for Diagnosis: 162.0

Diagnosis: Lung Cancer

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. Cardiothoracic stopped. No pulse present. VU NISKVD. O2 @ 2L NC. BP 90/70 P 60
1:35. No radial @ hand. Feet ↑ & response. Vital signs. 1:38 Pct.
911 called. 1:40 Responded to patient name. Eyes open. APPLIED
1:45. EMT here. HR reg rhythm (64) Pt responsive. Informed of transport to Woodhull hospital. Pt transported via ambulance to Woodhull hospital. [Redacted] present.

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 medication - O2

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.

Mary Beth Rosser RN

Michelle Tahner 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]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

40927
LICENSE NUMBER

1/15/03
DATE REPORT COMPLETED

4:20
TIME REPORT COMPLETED

221

Handwritten initials/signature



STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT

02 FEB -5 AM 7:15

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

*Contrast reaction
no procedure
N/A*

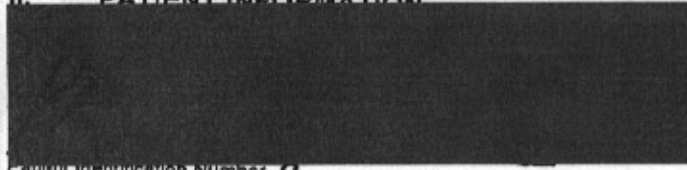
SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14000,
Tallahassee, Florida 32317-4000

I. OFFICE INFORMATION

Tallahassee Diagnostic Imaging
Name of office Radiology Associates of Tallahassee
Talla 32308 Leon
City Zip Code County
Dr. Arjun Kaji MD.
Name of Physician or Licensee Reporting
1541 Medical Dr. Talla, FL 32308
Locating information for Physician or Licensee Reporting

1623 Medical Dr.
Street Address
(850) 656-2261
Telephone
ME 76096
License Number

II. PATIENT INFORMATION



Age 01-28-03 Gender Male Medicaid Medicare
Date of Office Visit 01-28-03
Purpose of Office Visit CTA (Head)
ICD-9 Code for Diagnosis 780.2

Diagnosis Syncope

III. INCIDENT INFORMATION

01-28-03 11 AM
Incident Date and Time

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)

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

B) ICD-9-CM Codes

CTA (Head)

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)

CT LightSpeed CT machine

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.

William B. Tully RTN (RN 944732) 1623 Medical Dr. Tallahassee, FL 32308

Amber McIver LPN (PN 5147752) 1623 Medical Dr. Tallahassee, FL 32308

Kim Herold RN (RN 3302392) 1623 Medical Dr. Tallahassee, FL 32308

Dr. Tim Sweeney MD (ME 80205) 1541 Medical Dr. Tallahassee, FL 32308

Dr. Arjun Raji MD (ME 76096) 1541 Medical Dr. Tallahassee, FL 32308

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)

N/A

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

N/A

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 76096
LICENSE NUMBER

01.28.03
DATE REPORT COMPLETED

2:15 PM
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

CONSULTATION SERVICES UNIT
02 FEB -7 AM 7:11

W/A

UN SIGNED
NO PROCEED

I. OFFICE INFORMATION

Oncology/Hematology Assoc. of W. Broward
Name of office

7431 N. University Dr. Ste 110
Street Address

TAMARAC 33321 BROWARD
City Zip Code County

954-726-0035
Telephone

Abraham Rosenberg MD
Name of Physician or Licensee Reporting

ME 32992
License Number

7431 N. University Dr. Ste 110 TAMARAC, FL 33321
Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]

Parent/Communication Number

01/28/03
Date of Office Visit

Lymphoma
Diagnosis

INITIAL CONSULT
Purpose of Office Visit

202.80
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

01/28/03 Approx 1145 AM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other MD OFFICE EXAM ROOM

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

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

PATIENT FOUND SITTING IN EXAM ROOM CHAIR CHIN TO CHEST. UNRESPONSIVE TO VERBAL OR TACTILE STIMULI. SKIN WARM AND DRY, FACIAL COLOR ASHEN. NO RADIAL OR CAROTID PULSE FELT, NO RESPIRATIONS. 911 CALLED. PATIENT MOVED TO FLOOR. INCONTINENT OF URINE. AIRWAY OPENED. MEDIUM ADULT OROPHARYNGEAL AIRWAY PLACED. AMBU BAG ENGAGED AND COMPRESSED Q 5 SECONDS. O₂ ATTACHED TO AMBU AT 4L/MIN. SIMULTANEOUSLY PERIPHERAL IV STARTED @ 249 CATHETER @ UPPER EXTREMITY. NSS INFUSING WIDE OPEN. CAROTID PULSE FELT - QUALITY STRONG. EMS ARRIVED, TRANSPORTED PATIENT TO UNIVERSITY HOSPITAL.

B) ICD-9-CM Codes

none Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)
probable seizure Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)
none 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	<input type="checkbox"/> ** If it resulted in
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure	<input type="checkbox"/> Death
<input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a licensed hospital	<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.

ABRAHAM ROSENBERG MD ME 32992
LORRAINE UZZI LUKSTEID LPN PN 34750-i
SUSAN POTENBERG RN RN 148592
ARLENE BABISCKO RN RN 927872

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

LORNA DAWKINS RN RN 1567892
NANCY DELUSO RN RN 952582

IV. ANALYSIS AND CORRECTIVE ACTION

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

possible seizure

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

none

V.

[Signature] ME 0037592
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

3/3/03
DATE REPORT COMPLETED

11:00 AM
TIME REPORT COMPLETED

223

N/A



Unospsu
NA Proceed

223

STATE OF FLORIDA
Jeb Bush, Governor

RECEIVED
CONSUMER SERVICES UNIT
03 FEB 11 AM 7:23

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

MB 0056136
License Number & office registration number, if applicable

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

II. PATIENT INFORMATION

[Redacted Patient Information]

Age 1-23-03 Gender Male Medicaid Medicare

Neurogenic bladder, UTI
Diagnosis Quadriplegia

UTI
Date of Office Visit

3990
Purpose of Office Visit

NA
ICD-9 Code for description of incident
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1-23-03 at 2⁰⁰ pm
Incident Date and Time

Location of incident:
 Operating Rm Recovery Rm
 Other Phys 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 brought to office for visit regarding
worsening. Determined patient needed to be
admitted to hospital for continued treatment and
due to lack of transportation and patient's
quadriplegic condition [redacted] was transferred
to hospital via ambulance.

N/A



no procedure

BB 206

224



STATE OF FLORIDA
Jeb Bush, Governor

CONSUMER SERVICES UNIT
03 FEB 18 AM 7:06

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 Inst.
City: Brooksville Zip Code: 34613 County: Hernando

FLORIDA CANCER INSTITUTE, P.A.
11307 CORTEZ BLVD.
BROOKSVILLE, FL 34613
Street Address: (352) 596-1926 FAX (352) 597-2154

Name of Physician or Licensee Reporting: Sharon R Robitille RN OCW
Patient's address for Physician or Licensee Reporting: 4960 Cedarbrook Lane
Hernando Beach FL 34607

Telephone: RN 3176322
License Number & office registration number, if applicable

II. PATIENT INFORMATION

Pat: [Redacted]
Pat: [Redacted]
Pat: [Redacted]

Age: [Redacted] Gender: [Redacted] Medicaid: [Redacted] Medicare: [Redacted]

Diagnosis: small cell lung cancer

Date of Office Visit: 2-4-03
Purpose of Office Visit: initial visit to set up for chemotherapy
ICD-9 Code for description of incident: 780.2
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Incident Date and Time: 2/4/03 1015 AM

Location of Incident:
 Operating Rm Recovery Rm
 Other exam room

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

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

while Doctor explaining patients cancer and treatment patient became very pale and diaphoretic B/P dropped from 140/60 to 58 palpated HR dropped to 38 and became very irregular

COPIED TO [unclear] 2-10-03

PHYSICIAN OFFICE
ADVERSE INCIDENT

B) ICD-9-CM Codes

1102.3

780.2

unknown

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 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.

Dr Richard Caradonna
Sharon Robitelli RN

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

ANALYSIS AND CORRECTIVE ACTION

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

~~Trigger~~ Questionable cardiac event - pt has cardiac history

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

Oxygen applied - pt monitored until EMS arrived and transported pt to Oak Hill Hospital a ambulance

Signature of Physician/Licensee Submitting Report
Sharon Robitelli RN

License Number
RN 3176322

Date Report Completed
2/4/03

Time Report Completed
11:00 AM

YHW
2-10-03

225

N/A
No procedure



Chemo Room
[Signature]

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

Oncology/Hematology Assoc. of W. Broward
Name of office

7431 N. UNIVERSITY DR. Ste 110
Street Address

TAMARAC 33321 BROWARD
City Zip Code County

954-726-0035
Telephone

ABRAHAM ROSENBERG MD
Name of Physician or Licensee Reporting

ME0032992
License Number

7431 N. UNIVERSITY DR. Ste 110
Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient ID]

[Redacted Patient Info]
Age Gender Medicaid Medicare

COLON CANCER
Patient Identification Number
Diagnosis

01/16/03
Date of Office Visit
CHEMOTHERAPY ADMINISTRATION
Purpose of Office Visit
153.0
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

01/16/03 1430
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other PHYSICIAN OFFICE
CHEMO ADMINISTRATION ROOM

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

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response) ANZEMET 150mg INFUSED 1400-1415.

INFUSION OF ELOXATIN 195mg AND LEUCOVORIN 500mg BEGAN IV AT 1430.
RATE OF 250cc/Hr. BASELINE B/P 130/84. 10 MINUTES AFTER INFUSION
BEGAN, PATIENT REPORTED "NOT FEELING SO GOOD." PATIENT DIAPHORETIC,
PALE, B/P 84/58, P-100. CHEMO INFUSION STOPPED. NSS INFUSING. DR.
ROSENBERG IN TO SEE PATIENT. BLOOD SUGAR 132 VIA ACCUCHECK. EKG COMPLETED.
PT c/o NAUSEA. B/P @ 1505 - 120/80, P-96. V.S. @ 1520: B/P 104/70, P-96
PATIENT TAKEN TO ER VIA W/C ACCOMPANIED BY 2 RN'S.

3 FEB 17 AM 7:40
CONSUMER SERVICES UNIT

B) ICD-9-CM Codes

chemotherapy infusion
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 800-899.9)

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

(Use additional sheets as necessary for complete response)

none

D) Outcome of Incident (Please check)

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

<u>ABRAHAM ROSENBERG MD</u>	<u>ME32992</u>	<u>7431 N. UNIVERSITY DR.</u>	<u>PHYSICIAN</u>
<u>NANCY PELUSO RN</u>	<u>RN 952582</u>	<u>SAME</u>	<u>CHEMOTHERAPY NURSE</u>
<u>LORNA DAWKINS RN</u>	<u>RN 1567892</u>	<u>SAME</u>	<u>TRANSPORT CHEMOTHERAPY NURSE</u>
<u>SHARON JEFFERS RN</u>	<u>RN 3196772</u>	<u>SAME</u>	<u>TRANSPORT CHEMOTHERAPY NURSE</u>

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)

unknown cause

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

Continued vigilance of patients receiving chemotherapy

V.

[Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

12/10/03
DATE REPORT COMPLETED

7:30
TIME REPORT COMPLETED

ME0032992
LICENSE NUMBER

Robert J. Loewinger, MD
49 Royal Palm Pointe
Suite 100
Vero Beach, Florida 32960
(772)569-5056 Fax # (772)562-5098



MEDICINE BOARD
2003
2003 FEB 20 PM 2:28

Confidential/Work Product

February 13th, 2003

55
Denindex.net

226

03 MAR -6 AM 7:11
CONSULT SERVICES UNIT

Dear Sirs,

Pursuant to statute 458.351, I am reporting an alleged (possible) adverse incident in a practice setting.

(4)(d) 1. The performance of a wrong site surgical procedure.

The patient, [redacted] had a biopsy to [redacted] upper lip performed on 1/22/2003 by Christopher J. Carlisle, PA-C. The biopsy specimen was transported by courier to Ameripath where a dermatopathologist read the supplied specimen as an intraepithelial squamous cell carcinoma arising from an actinic keratosis. The patient underwent Mohs micrographic surgery and repair of subsequent defect on 2/4/2003.

The procedure we follow for the Mohs procedure is as follows: The patient undergoes informed consent and signs the informed consent form. The patient's chart is checked, confirming the diagnosis (pathology report), and the chart diagram of the location of the lesion, and then the patient is examined with magnification and bright light to locate the surgical site. The patient's lesion is then anesthetized with a local anesthetic, a small 00 curette is utilized to curette the site. Normal tissue does not curette or scrape out, thus by curetting the area, we confirm that the site does in fact have abnormal tissue and also to better define the actual margins of the abnormal tissue. Then the skin is prepped with Hibiclens, the surgical site is draped with sterile drapes and a disk of tissue is removed with a 1mm margin of normal tissue in a disk or pancake fashion. This excised tissue is then oriented according to position (superior, inferior, medial, lateral), and marked with dye on its edges to further orient the tissue. The tissue is then made into microscopic slides and stained with H&E stain so that the complete undersurface and edges can be examined for cancer cells.

In the case of patient [redacted] the size of the disk was 1mm x 2mm x 3mm. There was no cancer seen on the edges or in the depth of the tissue. Therefore, [redacted] wound was repaired in a fine line. The length of the repair was 1.5cm. [redacted] was seen for follow-up on 2/5/2003 and [redacted] wound appeared to be healing well. The patient was shown the surgical site and a then a new dressing was applied. [redacted] was seen again on 2/10/2003 and sutures were removed. The patient was shown the healing site and stated "That is not where the biopsy was", and pointed to another small area just slightly to the left, approximately 1/4" or less than 1 cm. away from where [redacted] was operated. When [redacted] pointed this out, we offered to perform surgery to remove the area of [redacted] concern, but [redacted] refused, declining further care.

In explanation of how this can happen, in cases of small lesions, the shave biopsy can remove a majority of the lesion. When the biopsy wound heals, the skin appears flat and in some cases the original biopsy site cannot be identified even under bright light and magnification. In cases when I am doing the Mohs procedure and I cannot identify any lesion (i.e. The skin looks entirely normal), I do a frozen section biopsy of the suspected area to verify location. If I can not find any cancerous cells in

WRONG SITE

Board cert, NO
Office Accidents

Hosp. Priv y

ME WAS TAKEN IN

WWW

227



228

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

*Abdominoplasty/liposuction
under general
↓ BP, ↓ PO₂*

I. OFFICE INFORMATION

Leonard Tachmes, M.D., P.A.
Name of Office
Aventura FL 33180 Dade
City Zip County
Leonard Tachmes, M.D., P.A.
Name of Physician or Licensee Reporting

875 NE 191st Street
Street Address
305-935-4655
Telephone
0065509
License Number

Locating Information for Physician or Licensee reporting

*Amplified
Brand cent
03 MAR 10 PM 7:26
CONSUMER SERVICES UNIT
Plas
S
Ages
YES, parkway hospi-
PLAS
SAC
Abdominoplasty*

II. PATIENT INFORMATION



Localizing Information
N/A
Patient Identification Number
Abdominoplasty/Liposuction Hips
Diagnosis

Age Gender Medicaid Medicare
Feb. 13, 2003
Date of Office Visit
Office Surgical Procedure
Purpose of Office Visit
278.1
ICD-9 Code for Diagnosis

*NOT
ACCREDITED*

III. INCIDENT INFORMATION

February 13, 2003 9:30 AM
Incident Date and Time

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

A) Describe circumstances of the incident (narrative)

Approximately 30 minutes from the start of case, patient developed sudden hypotension, which was treated with several anti-hypotensive medications, including intravenous epiheprine which was successful in elevating the blood pressure. Simultaneously, patient exhibited transient drop in oxygen saturation to 86% and brief cardiac PVC's. Immediately treated with I.V. Lidocaine which returned cardiac rhythm to normal.

911 paramedics were called, and surgery procedure was terminated. patient transported to Aventura Hospital emergency room. Dr. De La Torre, Anesthesiologist, accompanied patient in ambulance to the hospital. Patient was awake, responsive and stable in the hospital Emergency Room.

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

B) ICD-9-CM Codes

Abdominoplasty/
Liposuction-Hips

Surgical, diagnostic or treatment
being performed at time
incident
(ICD-9 Codes 01-991.9)

278.1

Unknown or Reaction to
General Anesthesia

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

None
Resulting Injury/Procedure
(ICD-9 Codes 800-999.9)

- C) List any equipment used if directly involved in the incident. N/A
- D) Outcome of Incident: Patient was transferred 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:

- 1- Leonard Tachmes, M.D., P.A. SURGEON # 0065509
- 2- Robert De La Torre, M.D. ANESTHESIOLOGIST- ME78337
- 3- Annett Osaria SCRUB TECH
- 4- Rosalle Silva CIRCULATOR

- F) List Witnesses, including license numbers, if licensed, and locating information if not listed above:

- IV. ANALYSIS AND CORRECTIVE ACTION:
 - A) All requirements for pre-operative assessment were satisfied
 - B) All procedures were followed correctly and no proactive or corrective action was required

V. L. Lawrence ME 0065509
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

2-26-03 2:00 pm.
 DATE REPORT COMPLETED TIME REPORT COMPLETED

Office visit
NO procedure
N/A



229

228



STATE OF FLORIDA
Jeb Bush, Governor

CONSUMER SERVICES UNIT
03 MAR 12 PM 7:02

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: Southeastern Urological Center, PA

Street Address: 2000 Centre Pointe Blvd

City: Tallahassee Zip Code: 32308 County: Leon

Telephone: 850-309-0400

Name of Physician or Licensee Reporting: Raleigh W Rollins

License Number & office registration number, if applicable: ME 0030010

Patient's address for Physician or Licensee Reporting: 25 2nd St

II. PATIENT INFORMATION



Age: 3-4-03 Gender: Male Medicaid: Yes Medicare: No

Diagnosis: Prostate Cancer

Date of Office Visit: 3-4-03

Purpose of Office Visit: routine follow up

ICD-9 Code for description of incident: NA

III. INCIDENT INFORMATION

Incident Date and Time: 3-4-03 @ 1530

Location of Incident:
 Operating Rm Recovery Rm
 Other CLINIC EXAM ROOM

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

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

Patient here for routine office visit. States feels funny like heart was racing. Called Dr. Rollins to listen to heart which Dr. Rollins described as rapid and regular, possible ventricular tachycardia which within minutes converted to normal sinus rhythm. Ambulance called and patient transported to TMC for further evaluation of cardiac status.

B) ICD-9-CM Codes

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

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

NA
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>Jacksonville Memorial</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.

Raleigh W. Koolins MD - MD caring for patient ordering transfer
Kathy Pralen PA - PA 203951 - assisting Dr. Koolins in clinic for patient
Terry Spear RN - RN 915912 - oversaw transfer + stayed with patient till ambulance arrived

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

NA

IV. ANALYSIS AND CORRECTIVE ACTION

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

Patient transferred appropriately and safely for cardiac assessment. Conditions unrelated to neurological diagnosis.

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

Patient appropriately transferred to hospital for further evaluation.

Terry Spear for Raleigh W. Koolins MD RN 915912 / ME0020010
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
3-5-05 1:00 hours
 DATE REPORT COMPLETED TIME REPORT COMPLETED

229

Office visit
no procedure



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

Career Centers of Florida
Name of office

Orlando 32806 Orange
City Zip Code County

Dr. Vinicio Hernandez
Name of Physician or Licensee Reporting

Same
Locating Information for Physician or Licensee Reporting

50 West Gore Street
Street Address

407-426-8484
Telephone

ME 0073340
License Number

II. PATIENT INFORMATION



174.4 Breast Cancer
Patient Identification Number
Diagnosis

3-3-2003
Date of Office Visit
Treatment / Follow-up Appt - MD
Purpose of Office Visit
174.4
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

3-3-2003 2:00pm
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other

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

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Pt presented w/ chest pressure and shortness
of breath; asked to go to the ER but
stated could not drive - 911 called
for transportation to ER @ DRMC

11:29

NIA

Diagnostic, or treatment
being performed at time of
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)

NIA

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 sensor 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.

Vinicio Hernandez, MD, Nicole Fernandez, CMA, Martha Cepero CMA

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)

[Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
3/3/03
DATE REPORT COMPLETED

ME 73340
LICENSE NUMBER

2:30 pm
TIME REPORT COMPLETED

230

STATE OF FLORIDA
Jeb Bush, Governor



CONSUMER SERVICES UNIT
03 MAR 19 AM 7:14

*Chemotherapy
weak
weak
weak*



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

Jeremiah Geffen MD & Assoc PA
Name of office d/b/a Geffen Cancer Center
Verobeach 32960 Indian River
City Zip Code County

981-37th Place
Street Address
(772) 770-5800
Telephone
License Number

Name of Physician or Licensee Reporting
Verobeach FL 32960
Locating information for Physician or Licensee Reporting

II. PATIENT INFORMATION



Age Gender Medicaid Medicare
Date of Office Visit 2-24-03
Purpose of Office Visit chemotherapy
ICD-9 Code for Diagnosis #162

III. INCIDENT INFORMATION

2-24-03
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other physician office

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

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

pt while leaving building after chemo therapy of carboplatin & taxol he was confused and excessively weak on feet. When attempting to stand up from a wheelchair to exit through door pt lost balance and listed to one side. At this time pt seemed to be confused and unaware of surroundings. pt reevaluated & taken back to chemo chair and 1/2 hr. of remained unaware of surroundings & name - transported to IRM Hospital ER for further evaluation.

B) ICD-9-CM Codes

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

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

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

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

None

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.

CONNIE OZMENT LPN 1558621 DR. Peter M. Kolencs MD 67425
JUANNINE SMITH RN 2199512 KIM KLEIN RN NP 2765262
MAUREN VONNAMA RN 1825752

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)

E.R. Transfer & evaluation

V. x Peter M. Kolencs, M.D.
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 67425
LICENSE NUMBER

2-24-02
DATE REPORT COMPLETED

1730
TIME REPORT COMPLETED

Breast Augmentation
Pneumothorax
no chest tube
in hosp 48 hours
CLNA



231

STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT
03 MAR 25 AM 7:05

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

Board cert, Plastic Surgeon
YES Accredited, AAASF
Hosp. Dir. Mance
Al.

I. OFFICE INFORMATION

Cosmetic Plastic Surgery Center of Ocala 1800 SW 17th St #700
Name of office Street Address
Ocala 34471 Marion
City Zip Code County
Dr. John D. Cohen-Shohet
Name of Physician or Licensee Reporting
Same as above
Patient's address for Physician or Licensee Reporting
Registration # 346
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted Patient ID]
Patient Identification Number
Bilateral Hypotrophic Breasts
Diagnosis
Age 33 Gender [Redacted] Medicaid Medicare
Date of Office Visit
Breast Augmentation
Purpose of Office Visit
SI-21
ICD-9 Code for description of Incident
Level I
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

3/3/03
Incident Date and Time
Location of Incident:
 Operating Rm Recovery Rm
 Other

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

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

98 lb pt undergoing submuscular breast augmentation.
Found to have extremely small intercostal muscle
& narrow space which lead to small puncture
when muscle was elevated. Small amt free
air entered chest cavity.

B) ICD-9-CM Codes

85.32
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)

51.21
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>Munroe 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.

ME 0039282 - Surgeon Dr Cohen-Shohet

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

RN 3344312 - CRNA 079767 - Certified Scrub Tech
RN 9170922 - circulating nurse

IV. ANALYSIS AND CORRECTIVE ACTION

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

Very small intercostal muscle due to patient size.

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

Sent to hospital & kept for observation x 48 hrs.
Treated medically. No need for chest tube.
This is the surgeons only occurrence of this nature in 20 yrs.

V. U. Quachain RN, BS, LHRM 5502394
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
3/3/03 1700
DATE REPORT COMPLETED TIME REPORT COMPLETED