[redacted]

STATE OF FLORIDA
Charlie Crist, Governor

FLORIDA DEPARTMENT OF HEALTH

RECEIVED JUN 3 0 2011 BY:

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Alyne Medical Rejuvenation Institute
Name of office

Weston | 33331 | Broward
City | Zip Code | County

Dr. Alberto Sant Antonio
Name of Physician or Licensee Reporting

2665 Executive Park Dr, Unit 1, Weston Fl
Patient's address for Physician or Licensee Reporting

2665 Executive Park Dr, Unit 1
Street Address

954-446-6464
Telephone

ME82484
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[redacted]
Patient Name
Patient's Address
Patient Identification Number
Diagnosis

6/11/2011 | [redacted] Gender | [redacted] Medicaid Medicare
Date of Office Visit

Liposculpture procedure
Purpose of Office Visit

Unable to locate ICD9 for this procedure
ICD-9 Code for description of incident

Level I
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

6/11/2011 at approximately 3:00PM
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)
(use additional sheets as necessary for complete response)

Please see Dr. Sant Antonio's Summary Note Dated June 18, 2011 attached.

DH-MQA1030-12/06
Page 1 of 2

physician inspector, Alcan? endless, tumescent anesthesia, general surgeon

LIPO
DEATH

cosmetic
gen surgeon.
Fla tx Rev
#55

00390

Maria Shortall

CA? = N
hp = N

tumescent lipo
fat grafting

LOB
unresponsive
ACLS

scheduled to have up to 4000cc
fat removed.

1000cc fat removed
500cc injected into buttocks

(A) pulmonary artery adipose tissue
embolism.

B) ICD-9-CM Codes
Tumescent Liposculpture Under Local Anesthesia

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 hospital.

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

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

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.
See sheet titled, "Personnel in the OR on 6/11/11" attached

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

IV. ANALYSIS AND CORRECTIVE ACTION

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

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

V. [signature] SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT — ME82484 LICENSE NUMBER

6/23/11 DATE REPORT COMPLETED — 6/23/11 TIME REPORT COMPLETED

Summary Note

RE: June 18, 2011

The patient arrived to the office at approximately at 1:00 PM on 6/11/11. [redacted] had eaten lunch as instructed prior to arriving at the office. I met with the patient and reviewed the treatment plan and answered any questions [redacted] had. I also performed a history and physical. [redacted] was then given Endocet 5/325 mg, Halcion 0.25 mg and Cephalexin 500 mg, orally as pre-procedure medications.

[redacted] then walked into the procedure room on [redacted] own and lay down in the supine position. A pulse oximeter was placed on [redacted] left index finger to continuously monitor [redacted] heart rate and oxygen saturation during the procedure. [redacted] skin was prepped with H202. Tumescent solution was then infiltrated into [redacted] right and left lateral waist with a 14 gauge needle. After approximately 1 liter of tumescent solution was infiltrated, [redacted] was asked to turn on [redacted] own in a prone position. Approximately 500 cc more of tumescent solution was infiltrated into the fatty tissues of the lower back. [redacted] was then asked to turn onto the left lateral position, which [redacted] did without difficulty. A # 15 scalpel blade was used to make multiple entry points in the tumesced area. At this point, 3 mm and 4 mm cannulas attached to a 60 cc Toomey syringe were used to begin extracting the fat and tumescent solution from the lower back area. As this was being performed tumescent solution was being infiltrated into the right mid back fat. As fat and tumescent solution was being removed from the right mid back fat the right upper back fat was being infiltrated with tumescent solution. As fat and tumescent solution was being removed from the right upper back, the left lower back fat was being infiltrated with tumescent solution while she was still in the left lateral position. 250 cc of the fat that had been removed from the right side of her back was saved in Toomey syringes. After about 25cc of tumescent solution was infiltrated into the right gluteal fat pad for anesthesia, the 250 cc of the saved fat was then injected into the right gluteal fat pad using a 4 mm cannula. Up to this point in time, the patient was alert, oriented appropriately and responding to commands and without complaints. Vital signs were stable throughout the procedure. At this point [redacted] was asked to turn supine and then to the right lateral position, which she did on her own without difficulty. Attention was then directed to her left lower back and the fat was removed from this area in a similar fashion as described above, while the tumescent solution was being injected into the left mid back fat. As the fat and tumescent solution was removed from the mid back, the left upper back was infiltrated with tumescent solution. Once the fat and tumescent solution was removed from the left upper back, infiltration was started in the lower abdomen. As before 250 cc of fat that had been saved in Toomey syringes was used to augment the left gluteal fat pad following infiltration of 25 cc of tumescent solution.

Up to this point the patient continued to be alert, oriented and without any complaints. [redacted] responded appropriately to verbal commands and vital signs remained stable. However, when [redacted] was asked to turn again in the supine position, [redacted] began to have difficulty getting her breath. Suddenly [redacted] became unresponsive and the pulse oximeter registered zero. The patient failed to respond to verbal command and CPR was immediately instituted. A pulse of over 100 and 100% oxygen saturation was achieved. However, it could not be maintained, at which I instructed a staff member to call 911. While we were waiting for emergency personnel to arrive, we continued with CPR and [redacted] pulse and O2 saturation would come and go was unresponsive to commands.

When the paramedics arrived, they removed [redacted] from the operating room table, placed [redacted] on the floor and put [redacted] in the auto pulse device. CPR was continued by the emergency personnel until [redacted] was transported to the Cleveland Clinic in Weston. .

Dictating Physician Alberto Sant Antonio

Alberto Sant Antonio, MD

Personnel in the OR on 6/11/11

NAME	TITLE	LICENSE #	CERTIFICATE #	CAPACITY
Alberto Sant Antonio	Medical Doctor	ME82484		Surgeon
Huberto Hernandez	Medical Doctor	ME41864		Medical Doctor
Jhon Suarez	Surgical Assistant		07-288	Surgical Assistant
Gustavo Romero	Surgical Assistant		09-310	Surgical Assistant
Jessica Hernandez	Medical Assistant		SS#075-76-4077	OR Clean up

Personnel outside OR but in OR area on 6/11/11

NAME	TITLE	LICENSE #	CERTIFICATE #	CAPACITY
Francisco Navarro	Surgical Assistant		09-145	Surgical Assistant
Norma Perez	OR Clean-Up Assistant		SS#766-66-0697	OR Clean Up
Annetta Sant Antonio	OR Clean-Up Assistant		SS#215-96-5465	OR Clean Up
Diane Sant Antonio	Front Desk Manager		SS#218-17-1855	Called 911
Lee Nelson	Office Manger		SS#255-78-4583	

7010 2780 0001 2575 1488

U.S. POSTAGE
FORT LAUDERDALE-FL
33302-11
JUN 23, '10
AMOUNT
$6.23
00016742-07

1000

32399

: 00395

No

19

STATE OF FLORIDA
Charlie Crist, Governor

FLORIDA DEPARTMENT OF HEALTH

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Strait Rejuvenation
Name of office

4300 N. University Dr. Suite A-202
Street Address

Coconut Creek, FL 33351 Broward
City Zip Code County

(954) 749-3040
Telephone

Paul M. Goldberg
Name of Physician or Licensee Reporting

N/A
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient's Address

N/A
Patient Identification Number

Aging Face & Eyes
Diagnosis

[redacted] ☐ ☐
Age Gender Medicaid Medicare

5-13-08 - 6-20-08
Date of Office Visit

Initial Consult - Surgery
Purpose of Office Visit

N/A
ICD-9 Code for description of Incident

Level I
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

6/20/08 - 6/21/08 11:00am - 1:00 pm
Incident Date and Time

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other Home

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)

Please attached

Staycie Butler - Surgical Tech
Linda Littlefield - R.N. 918002

B) ICD-9-CM Codes

15823-50
CPT 15828/15821-50
Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**

UNKNOWN
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)

- ☒ 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 hospital.

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

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

** if it resulted in:
- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function.
- ☐ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

LISA ARANA - Surgical Tech
STACIE BUTLER - Surgical Tech
LINDA LIZEWFKI - R.N. 918002

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)

SEE ATTACHED

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

SEE ATTACHED

V.

[signature] ME-93957
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

07/03/08
DATE REPORT COMPLETED TIME REPORT COMPLETED

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 hospital.

Outcome of transfer – e.g., death, brain damage, observation only Death
Name of facility to which patient was transferred:
Florida Medical Center

- ☐ 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 to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthasiologist, support staff and other health care providers.

ME 16754 - Dr. Bass

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

RN 9172991 - Kim Ritchie, RN

IV. ANALYSIS AND CORRECTIVE ACTION

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

Please see attached.

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

Please see attached.

V.

[signature] ME 16754
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

5/30/11 1230 PM
DATE REPORT COMPLETED TIME REPORT COMPLETED

It appears the patient died from natural causes and no corrective action is needed.

The patient was a [redacted] year old [redacted] who presented for facelift and eye surgery. Medical clearance was obtained and there were no contra indications to the scheduled procedures. On June 20, 2008 at Strax Rejuvenation and Aesthetics Institute, a face and neck lift, and upper and lower blepharoplasty's were completed by Paul Goldberg, M.D., under local anesthesia. The surgery was uneventful except for a thirty second interval where the patients PO2 level fell to 65. A plastic mouthpiece was inserted to depress [redacted] tongue and pulled forward on [redacted] jaw, as this appeared to be related to [redacted] snoring, administered 1 mg of Narcan, I.V., and the PO2 came back up almost immediately.

The patient was in recovery for 80 - 90 minutes and was discharged fully awake, ambulatory, and went home with [redacted] daughter.

According to information from the family, the patient ate dinner at about 6:00 p.m., went to bed and was checked on by family members several times during the night until about 1:00 a.m. At that time they found [redacted] not snoring ([redacted] had been on the earlier occasions) and cold. EMT was called, [redacted] was transported to North Broward Medical Center and pronounced dead after some attempt at resuscitation.

The Medical Examiner performed an autopsy and concluded the patient died of a myocardial infarction, although the report has not been received.

[redacted]

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STATE OF FLORIDA
Rick Scott, Governor

FLORIDA DEPARTMENT OF HEALTH

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Surgery Center of Broward County
Name of office

4300 N. University Dr., # A-202
Street Address

Lauderhill 33351 Broward
City Zip Code County

954-749-3040
Telephone

Harold Bass, M.D.
Name of Physician or Licensee Reporting

ME 16754 /OSR#626
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[redacted]
Patient Name

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

[redacted]
Patient's Address

5/16/11
Date of Office Visit

Patient Identification Number

Cosmetic surgery
Purpose of Office Visit

Bilateral neck laxity
Diagnosis

ICD-9 Code for description of incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

5/16/11 1609
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)
(use additional sheets as necessary for complete response)

Please see attached.

*See attached.

DESCRIBE CIRCUMSTANCES OF INCIDENT:

This [redacted] presented for lower blepharoplasty, neck lift revision and anterior platismaplasty. [redacted] had previously undergone cosmetic surgery under general anesthesia in 8/10 with no complications, and was an appropriate candidate for this procedure.

Pre-operative evaluations were done and the patient was cleared for surgery on 5/16. During the initial part of the procedure (the neck lift), although nothing unusual occurred during the surgery, the patient's vital signs suddenly changed, and [redacted] went into cardiac arrest. A code was called, and EMS was called (via 911) and the patient was resuscitated, however, [redacted] remained unresponsive. [redacted] was transferred to Florida Medical Center. Despite immediate medical intervention, the patient did not regain consciousness and expired on 5/19.

ANALYSIS AND CORRECTIVE ACTION:

At this time, there is no explanation for this event. The case was referred to the medical examiner, and we are waiting for the medical examiner's report to try to determine what happened.

Corrective action will be implemented as needed after we know what happened to the patient.

A-19 GK

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

1st complaint

PETITIONER,

v.

CASE NO. 2011-09782

ALBERTO SANT ANTONIO, M.D.,

RESPONDENT.

ADMINISTRATIVE COMPLAINT

The Petitioner, Department of Health, by and through the undersigned counsel, files this Administrative Complaint before the Board of Medicine against the Respondent, Alberto Sant Antonio, M.D., and in support thereof alleges:

1. The Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, the Respondent was a licensed physician within the state of Florida, having been issued license number ME 82484.

3. The Respondent's address of record is 16111 Emerald Estates Drive, Weston, Florida 33331.

4. The Respondent is not board certified in any specialty.

5. At all times material to this Administrative Complaint, the Respondent practiced at an office surgical center called Alyne Medical Rejuvenation Institute (Alyne), located at 2665 Executive Park Drive, Weston, Florida 33331.

6. Alyne is not registered as an office surgical center with the Department of Health.

7. Alyne is not registered with the Agency for Health Care Administration as an office surgical center.

8. On or about June 11, 2011, patient M.S., a 38 year old woman, presented to the Respondent.

9. M.S. was scheduled to have a liposuction and a fat graft.

10. M.S.'s liposuction was associated and directly related to her fat graft and was therefore, a Level II office surgery.

11. A liposuction performed in conjunction with a fat graft is a procedure that takes more than five minutes to complete.

12. The patient was scheduled to have up to 4000 cc of fat removed.

13. Prior to the procedure, the Respondent administered or ordered that the patient be administered the following drugs: Endocet 5/325 mg, triazalam 0.25 mg and cephalexin 500 mg.

14. Endocet 5/325 mg is the brand name for a drug that contains 5 mg of oxycodone and 325 mg of acetaminophen. Endocet is used to relieve moderate to moderately severe pain.

15. Triazalam is a hypnotic agent and is used as a sedative.

16. Cephalexin is an antibiotic.

17. The Respondent used lidocane as a local anesthetic during the procedure.

18. The Respondent did not have an anesthesiologist or a nurse anesthetist present during M.S.'s procedure.

19. The Respondent employed a pulse oximeter to monitor M.S. The pulse oximeter was placed on M.S.'s finger.

20. The Respondent did not adequately monitor M.S. or have M.S. adequately monitored during the procedure.

21. The Respondent did not use a cardiac monitor during surgery, nor did he have personnel monitoring the patient's cardiac rhythm.

22. The Respondent did not have personnel monitoring the patient's blood pressure.

23. The Respondent did not have personnel monitoring the patient's respiration.

24. The Respondent removed fat from M.S.'s midsection or back and then had the patient turn over to have the fat injected into her buttocks several times.

25. The Respondent removed approximately 1000 cc of fat and then injected approximately 500 cc of fat into M.S.'s buttocks.

26. During the course of the procedure, M.S. began to have difficulty breathing and then became unresponsive.

27. The pulse oximeter registered zero.

28. M.S. went into full cardiopulmonary arrest.

29. The Respondent and his staff started cardiopulmonary resuscitation (C.P.R.).

30. The Respondent had at least two crash carts at Alyne in an operating room across the lobby. The Respondent did not have a crash cart in the room when the procedure started.

31. After the patient became unresponsive, the Respondent ordered a crash cart to be brought into the operating room.

32. The Respondent ordered 911 to be called.

33. The Respondent failed to adequately diagnose and treat M.S.'s condition once she went into cardiopulmonary arrest.

34. After the patient went into cardiopulmonary arrest, the Respondent failed to establish an airway so that patient could get oxygen or air.

35. After the patient went into cardiopulmonary arrest, the Respondent did not employ a bag valve mask (B.V.M.).

36. After the patient went into cardiopulmonary arrest, the Respondent failed to establish intravenous access to provide M.S. fluids and medication.

37. After the patient went into cardiopulmonary arrest, the Respondent failed to diagnose the cardiac rhythm.

38. M.S. had been in arrest for approximately 10 minutes with only CPR being preformed when Emergency Medical Services (E.M.S.) arrived.

39. EMS instituted advanced cardiac life support.

40. EMS transported M.S. to Cleveland Clinic Hospital, where she was pronounced dead.

41. The Respondent performed additional procedures after EMS transported M.S. to the hospital.

42. The Respondent informed the Department that he is certified in Advance Cardiac Life Support.

COUNT I

43. The Petitioner realleges and incorporates paragraphs one (1) through forty-two (42) as if fully set forth in this count.

44. Section 458.331(1)(nn), Florida Statutes, (2010) provides that a medical doctor is subject to discipline for violating any provision of chapter 458 or chapter 456, or any rules adopted pursuant thereto.

45. Rule 64B8-9.009(1)(e), Florida Administrative Code, provides:

> Liposuction may be performed in combination with another separate surgical procedure during a single Level II or Level III operation, only in the following circumstances:
> 1. When combined with abdominoplasty, liposuction may not exceed 1000cc of supernatant fat;
> 2. When liposuction is associated and directly related to another procedure, the liposuction may not exceed 1000 cc of supernatant fat;

3. Major liposuction in excess of 1000cc supernatant fat may not be performed in a remote location from any other procedure.

46. The Respondent performed a liposuction associated and directly related to another procedure (the fat graft). M.S.'s fat graft was associated and directly related to M.S.'s liposuction in that he removed fat from her back or side and then injected the fat into M.S.'s buttocks.

47. The Respondent performed a Level II surgery.

48. The Respondent had scheduled M.S. to have up more than 1000 cc of supernatant fat removed and have a fat graft performed at the same time.

49. The Respondent removed approximately 1000 cc of supernatant fat from M.S. while performing a fat graft when the patient when into cardiac arrest.

50. Based on the foregoing, the Respondent violated Section 458.331(1)(nn), Florida Statutes, (2010) when he violated Rule 64B8-9.009(1) by performing a liposuction directly related to another procedure (the fat graft) and attempting to extract more than 1000 cc supernatant fat.

COUNT II

51. The Petitioner realleges and incorporates paragraphs one (1) through forty-two (42) as if fully set forth in this count.

52. Section 458.331(1)(nn), Florida Statutes, (2010) provides that a medical doctor is subject to discipline for violating any provision of chapter 458 or chapter 456, or any rules adopted pursuant thereto.

53. Rule 64B8-9.0091(1)(a), Florida Administrative Code, is titled "Requirement for Physician Office Registration; Inspection or Accreditation" and provides in pertinant part:

> Every licensed physician who holds an active Florida license and performs Level II surgical procedures in Florida with a maximum planned duration of more than five (5) minutes or any Level III office surgery, as fully defined in Rule 64B8-9.009, F.A.C., shall register the office with the Department of Health. It is the physician's responsibility to ensure that every office in which he or she performs Levels II or III surgical procedures as described above is registered, regardless of whether other physicians are practicing in the same office or whether the office is non-physician owned.

54. The Respondent is a licensed physician who holds an active Florida License and performed a Level II procedure in Florida which exceeded five minutes.

55. The Respondent did not register Alyne with the Department of Health.

56. Based on the foregoing, the Respondent violated Section 458.331(1)(nn), Florida Statutes, (2010) when he violated Rule 64B8-9.0091(1)(a), Florida Administrative Code, when he failed to register Alyne and performed a Level II surgical procedure which was scheduled to exceed five minutes.

COUNT III

57. The Petitioner realleges and incorporates paragraphs one (1) through forty-two (42) as if fully set forth in this count.

58. Section 458.331(1)(nn), Florida Statutes, (2010) provides that a medical doctor is subject to discipline for violating any provision of chapter 458 or chapter 456, or any rules adopted pursuant thereto.

59. Rule 64B8-9.009(4), Florida Administrative Code, is titled "Standards for Level II Office Surgery" and provides:

> (b) Standards for Level II Office Surgery.
> 3. Equipment and Supplies Required.
> a. Full and current crash cart at the location the anesthetizing is being carried out. The crash cart must include, at a minimum, the following resuscitative medications:
>
> ...
>
> 4. Assistance of Other Personnel Required. The surgeon must be assisted by a qualified anesthesia provider as follows: An Anesthesiologist, Certified Registered Nurse Anesthesist, or Physician Assistant qualified as set forth in subparagraph 64B8-30.012(2)(b)6., F.A.C., or a registered nurse may be utilized to assist with the anesthesia, if the surgeon is ACLS certified. An assisting anesthesia provider cannot function in any other capacity during the procedure. If additional assistance is required by the specific procedure or patient circumstances, such assistance must be provided by a physician, osteopathic physician, registered nurse, licensed practical nurse, or operating room technician. A physician licensed under Chapter 458 or 459, F.S., a licensed physician assistant, a licensed registered nurse with post-anesthesia care unit experience or the equivalent, credentialed in Advanced Cardiac Life Support or, in the case of pediatric patients, Pediatric Advanced Life Support, must be available to monitor the patient in the recovery room until the patient is recovered from anesthesia.

60. The Respondent failed to meet the Standards for Level II Office Surgeries in one or more of the following ways:

a. the Respondent did not have a full and current crash cart at the location the anesthetizing was being carried out; and/or

b. the Respondent did not have a qualified anesthesia provider working with him nor did he have a registered nurse assist him.

61. Based on the foregoing, the Respondent violated Section 458.331(1)(nn), Florida Statutes, (2010) when he violated Rule 64B8-9.009(4)(b), Florida Administrative Code, when he failed to meet the Standards for Level II Office Surgeries.

COUNT IV

62. The Petitioner realleges and incorporates paragraphs one (1) through forty-two (42) as if fully set forth in this count.

63. Section 458.331(1)(t)1, Florida Statutes (2010), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2010), defines medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

64. 'The level of care, skill, and treatment recognized in general law related to health care licensure' means the standard of care specified in

Section 766.102. Section 766.102(1), Florida Statutes (2010), defines the standard of care as

> [t]he prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

65. The Respondent failed to meet the prevailing standard of care by failing to have M.S. adequately monitored during surgery in one or more of the following ways:

a. the Respondent did not use a cardiac monitor during surgery;

b. the Respondent did not have personnel monitoring the patient's blood pressure; and/or

c. the Respondent did not have personnel monitoring the patient's respiration.

66. The Respondent failed to meet the prevailing standard of care by failing to diagnose and treat M.S. after she went into arrest in one or more of the following ways:

a. the Respondent failed to establish an airway so that patient could get oxygen or air;

b. the Respondent did not employ a BVM;

c. the Respondent failed to establish intravenous access to provide M.S. fluids and medication; and/or

d. the Respondent failed to diagnose M.S.'s cardiac rhythm.

67. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes (2010), by committing medical malpractice.

WHEREFORE, Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 28nd day of July, 2011.

H. Frank Farmer, Jr., MD, PhD, FACP
State Surgeon General

Grace Kim

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FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE JUL 25 2011

/gk
PCP: July 22, 2011
PCP Members: El-Bahri, Espinola & Mullins

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.