

B) ICD-9-CM Codes

36595, 36581
 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)

N/A

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 hospital. Outcome of transfer - e.g., death, brain damage, observation only <u>admitted for thrombolytic</u> Name of facility to which patient was transferred: <u>Therapy at Florida 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: <u>N</u> <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input type="checkbox"/> Any condition that required the transfer of the patient to a hospital.
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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.

DR. A. Kramer ME 115193
Jessica Walters RN 9217944 (RN)
Sheryl Browner RN 1807112 (RN)
Nurture Paul, RRT CRT-54011 (RT)

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)

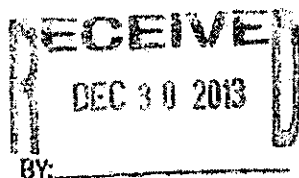
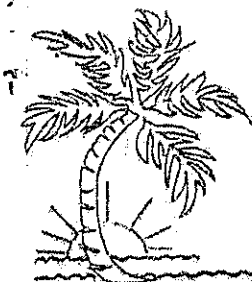
Continue to ensure each patient's care and treatment regimen is based on the individual's needs and that a full assessment of the access being treated is complete prior to discharge. This includes all aspects of care are complete and ensure communication with the primary nephrologist is maintained and that he or she is part of the treatment plan.

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

N/A

V.

Akron D ME 115193
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
12-23-13 1700
 DATE REPORT COMPLETED TIME REPORT COMPLETED



Ft. Lauderdale Access Center

December 23, 2013

Dear Consumer Services Unit,

Please see accompanying Physician Office Adverse Incident Report from OSR 179. In Brief, the patient [REDACTED] patient was referred to the Access Center for a poorly functioning tunneled Dialysis catheter. LIP, Dr. A. Kamra performed an SVC angiogram (Superior Vena Cava) and noted the presence of a fibrin sheath. He performed a disruption of fibrin sheath, as well as a Right IJ catheter exchange. Dr. Kamra noted the arterial port was not aspirating with ease. Additional angiography was performed and MD noted a right atrial thrombus. Dr. Kamra spoke with the patient and the patient's primary Nephrologist (Dr. Gadh) to discuss findings and Plan of Care. Patient's PCP (Dr. Gupta) was also made aware of findings. Patient was asymptomatic throughout and vital signs were stable. [REDACTED] was transferred via EMS to Florida Medical center for further evaluation and treatment. A DVD of the study as well as a vascular diagram was sent with patient to Florida Medical Center to help the treating MD have a better understanding of this patient's needs.

Spoke to [REDACTED] 24 and 48 hours after admit to Florida Medical Center: [REDACTED] was doing well was being treated with thrombolytic therapy to reduce the clot burden. He was able to get dialysis via the tunneled dialysis catheter. Patient is now back at home. This information was obtained from the patient's wife.

If any further information is needed please feel free to contact me, Sheryl Browner. My contact information can be found below.

Sincerely,

Sheryl Browner RN

Administrator

Ft. Lauderdale Access Center

3601 W. Commercial Blvd.

Suite 21

Ft. Lauderdale, FL 33309

(PH) 954-497-2161 (FAX) 954-535-5507

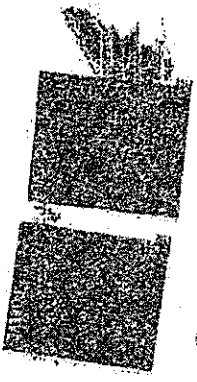


Ft. Lauderdale Access Center

3601 W. Commercial Blvd, Suite 21 Ft. Lauderdale, FL 33309

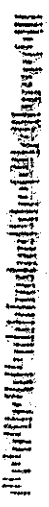
RECEIVED

25 DEC 2003 PM 12



Department of Health, Consumer Service Unit
4052 Bald Cypress way, Bldg 75
Tallahassee, Florida 32399-8275

32399827599



Enforcement Search Listing

Rec. Pref. Number	Stat. Date	Source	Status	Incident Date	Disp.	Respondent Name	A/c Type	File No.	Arrest	Public Case
1501	2013/07/23	12/20/2013	58	10	12/05/2013	KARMA, AMIT KUMAR	NSR	114103	125553	
1501	2013/06/22	12/30/2013	58	0	12/29/2013	KARMA, AMIT KUMAR	NSR	125115	115152	

169

59

NO
repeat

DOH Consumer Services
JAN 03 2014



STATE OF FLORIDA
Rick Scott, Governor

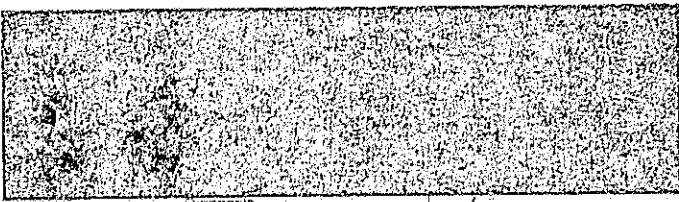
PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C76
Tallahassee, Florida 32399-3276

I. OFFICE INFORMATION

Name of office: MYLOOKS Boca Raton
City: Boca Raton Zip Code: 33432 County: Lake
Name of Physician or Licensee Reporting: Lawrence Koslowski MD FACS
Patient's address for Physician or Licensee Reporting: Same as above

Street Address: 200 Willetts Rd Suite 1 Boca Raton, FL
Telephone: 561-416-1272
License Number & Office registration number, if applicable: ME50335



Diagnosis

Age: 70 Gender: Female Medicaid: 0 Medicare: 0 N/A
Date of Office Visit: 12/20/2013
Purpose of Office Visit: Surgical Abx + idctomy
ICD-9 Code for description of Incident: (11)
Level of Surgery (II, or (III): (11)

III. INCIDENT INFORMATION

Incident Date and Time: 12/20/2013 3AM

Location of Incident:
 Operating Room
 Other: Patients home
 Recovery 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)

See Dictated Narrative: Patient

B) ICD-9-CM Codes 86.82/373.4
Rhytidectomy/Upper Bleph Not Applicable Acute CVA
 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.8) 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)
Rhytidectomy Kit and Upper Blepharoplasty Kit

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 hospital. Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred: <u>DeJoy 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 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.

Dr Lawrence Kordeck - ME 50035 Surgeon
Raphael Tamer - CRNA Anesthesia Provider APRN 0198123
Melissa Grillo - Circulating RN and Backstage RN 9353495
Anika Chen-Spaul - Scrub Tech #120024 / LPN 5100000
Daniella Garabedian - Overnight RN 9273401

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)

see attached

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

V.

SIGNATURE OF PHYSICIAN/LICENEE SUBMITTING REPORT

ME 50035
 LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

January 2, 2014

[REDACTED]

To Whom It May Concern:

[REDACTED] is a patient of ours who underwent surgical rhytidectomy with upper lid blepharoplasty in our AAAASF certified facility on December 17, 2013. The patient was initially seen in our office for consultation regarding the surgical procedure on October 24, 2013. At that point, her complete medical history as well as her surgical expectations were reviewed with the patient and her husband. On the patient's medical history form, it was noted that she did have chronic well controlled hypertension. At that time of her initial consultation, her blood pressure was taken in the office and was revealed to be 142/86. This was considered borderline high and we advised the patient to do a blood pressure log for approximately two weeks at a time, taking it at different times of the day, recording it, and then bring this into our office so we could reevaluate her blood pressure. She did do a blood pressure log starting on November 6, 2013 and continued it for two weeks. On evaluation of the blood pressure log at her preoperative visit, she was normotensive and had no evidence of any hypertension. We also did get a cardiac clearance with her cardiologist who also cleared her for her upcoming surgical procedure. At her preoperative visit on December 13, 2013, her medical clearance, all of her preoperative laboratory examinations, as well as her EKG were reviewed with the patient as well as the surgical procedure and potential risks and complications.

She then underwent the surgical procedure which consisted of a facial rhytidectomy and upper lid blepharoplasty in our AAAASF Certified Operating Facility. The surgical procedure went without incident and she had no problems maintaining a normal blood pressure both intraoperatively and postoperatively. The following day after her surgery our medical personal was sent to her home to review her postoperative care and recheck her vital signs. At that time, she was doing well at home and normotensive. She was tolerating a diet and ambulating around the house. She was seen in the office for her first postoperative visit on December 19, 2013.

[REDACTED]
January 2014

Page 2

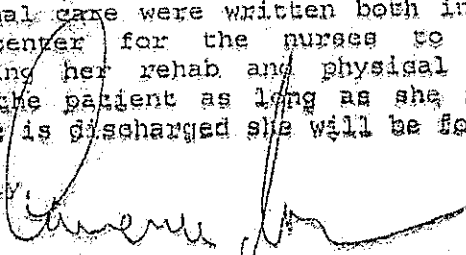
At that point, she had very minimal swelling with hardly any bruising and excellent improvement in the contour of her neck and lower face. The stitches from her upper eyelids were removed. She was given explicit instructions on how to take care of her rhytidectomy incisions and was advised to increase her level of ambulation around the house. The surgical dressing was also removed and she was placed in an elastic neck band. On the early morning of December 20, 2013, at 3 a.m., I was called by my answering service to notify me that the patient got out of bed and collapsed. The husband noted that she could not move the entire right side of her body and she had slurred speech. He immediately called 911 which arrived within minutes and evaluated the patient for CVA or stroke. The patient was then taken directly to Delray Community Hospital Emergency Room, which was the nearest hospital to where the patient lives and evaluated in the Emergency Room and admitted with a diagnosis of an acute CVA. At that time, the patient's blood pressure was still normal and a neurologist was consulted. The patient underwent CT scans which were negative but a MRI scan revealed that she had a thrombosis of her basilar artery resulting in the CVA. The patient was admitted to the Neurointensive Care Unit and started on immediate Heparinization under the guidance of the neurologist and her cardiologist. I continued to follow the patient at the hospital almost on a daily basis and over the next 24-48 hours she made a dramatic improvement. By the third day in the Neurointensive Care Unit, the patient was now talking with a dramatic improvement in her expressive aphasia and starting to move the right side of her body. On December 26, 2013, the patient was switched to Coumadin from I.V. Heparin and transferred out of the Neuro-ICU onto stepdown Neurology floor in the hospital and then transferred to Pinecrest Rehab Center for rehabilitation. I saw the patient on December 31, 2013, in the rehab center and at that point the patient was ambulating with a walker, had movement of her right arm and right leg, and her expressive aphasia was completely cleared up. In terms of her surgical results, she did not develop any type of hematoma or flap ischemia from her surgical procedure of her facelift and all the incisions healed very nicely with excellent improvement in both her neck/lower face contour.

January 2014

Page 3

Her upper eyelid incisions were completely healed. Instructions on incisional care were written both in the hospital as well as in the rehab center for the nurses to follow while the patient was undergoing her rehab and physical therapy. We will continue to follow the patient as long as she is in the rehab center and then when she is discharged she will be followed up in the office.

Sincerely,



Lawrence M. Korpeck, M.D.
LMK/dl



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
JUL 30 2013
BY:

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

I. OFFICE INFORMATION

Name of office: Vanidades Cosmetic Surgeon Laser
City: Miami Zip Code: 33144 County: Miami Dade
Name of Physician or Licensee Reporting: Anthony Hasan MD.
Patient's address for Physician or Licensee Reporting: plm

Street Address: 8500 SW 8 ST
Telephone: 305. 262-6070
License Number & office registration number, if applicable: OSR. 350

II. PATIENT INFORMATION

Patient's Address: [Redacted]
Patient Identification Number: [Redacted]
Diagnosis: Lipodystrophy of abdominal/flanks, full back, flat atrophic buttock

Age: [Redacted] Gender: [Redacted] Medicaid Medicare: [Redacted]
Date of Office Visit: 7.11.2013
Purpose of Office Visit: Surgery
ICD-9 Code for description of incident: 158.77 + 119.54
Level of Surgery (II) or (III): III

III. INCIDENT INFORMATION

Incident Date and Time: 7.11.2013 9:35am

Location of Incident:
 Operating Room
 Recovery Room
 Other

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

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

SEE Attached Surgeon + Anesthetist NOTES

PROGRESS NOTE

DATE: 7 / 11 / 13

PATIENT NAME: [REDACTED]

Pt. had underwent a liposuction with fat transfer to the gluteal region. The procedure ended uneventful. Pt. was then transferred to post anesthesia recovery unit. Upon arrival, patient's blood pressure began to drop. During [REDACTED] time in the recovery room, patient was alert, awake, and responsive to all commands. All measures to stabilize patient's vital signs were taken, but response was minimal. Immediately 911 was called, and rescue came and transferred Ms. Cardona to Kendall Regional Hospital.

I arrived to the hospital shortly after receiving a call from the trauma surgeon's staff. I was told patient's condition was becoming worse. The trauma surgeon (Mark McKenny) told me a CT scan showed pulmonary embolism, possibly due to fat. There was no indications of abdominal or thoracic trauma. Pt. passed away after approx. three hours at the hospital.

PROGRESS NOTE

DATE: 07/11/2013

PATIENT NAME: [REDACTED]

Pt was transferred to the post anesthetic recovery unit immediately after surgery proceeded without any adverse event. After arrival and immediately after monitoring started abnormal vital signs were detected. Pt alert and responding to command with no apparent neurological compromise began to manifest severe hypotension accompanied by tachycardia, hypoxemia, and tachypnea. Resuscitation measures were started immediately without any response. Because of hemodynamic instability, I decided the patient must be transferred to nearest level 3 medical center. Pt was transferred via air ambulance to Kendall Medical Center approx. 45 min after completion of the surgery procedure.

PORU of arrival. BP 85/40 SpO₂ 92% RR 10 1/min O₂ by F.O₂.

HR 127x EKG. Sinus tachycardia

Resp. compromised by AHA 4013 No focal neuro deficit.

CV. Tachycardia 3:52 no 4. No murmurs. No S4. No S3. No JVD.

Ref. (B) ETA No exam

Tx - Ephedrine 10mg IV.

Phenylephrine 400mcg IV.

RR 1000ml.

O₂ face mask @ 10 1/min.

FILED DATE AUG 13 2013
Department of Health
By: Ornel Sude
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2011-09782
2011-11371
LICENSE NO.: ME0082484

ALBERTO SANT ANTONIO, M.D.,

Respondent.

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) on August 2, 2013, in Deerfield Beach, Florida, for the purpose of considering Respondent's offer to voluntarily relinquish his license to practice medicine in the State of Florida. (Attached hereto as Exhibit A.) Said written offer of relinquishment specifically provides that Respondent agrees never again to apply for licensure as a physician in the State of Florida.

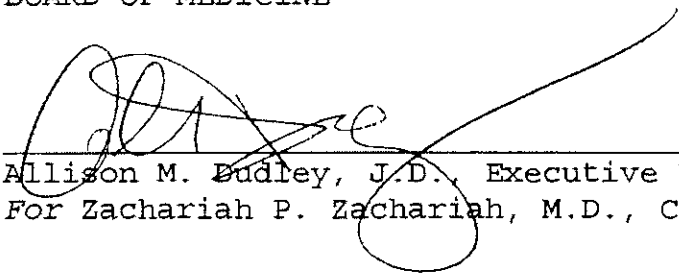
Upon consideration of the written offer of voluntary relinquishment, the charges, and the other documents of record, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED that Respondent's Voluntary Relinquishment of his license to practice medicine in the State of Florida is hereby ACCEPTED, and shall constitute discipline upon Respondent's license.

This Final Order shall take effect upon being filed with
the Clerk of the Department of Health.

DONE AND ORDERED this 12th day of August,
2013.

BOARD OF MEDICINE


Allison M. Dudley, J.D., Executive Director
For Zachariah P. Zachariah, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the
foregoing Final Order has been provided by U.S. Mail to ALBERTO
SANT ANTONIO, M.D., 16111 Emerald Estates Drive, Weston, Florida
33331; to Ariel Sofro, Esquire, Law Firm of Lubell & Rosen, 200
Andrews Avenue, Suite 900, Fort Lauderdale, Florida 33301; and
by interoffice delivery to Doug Sunshine, Department of Health,
4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-
3253 this 13th day of August, 2013.


Bridget Sanders

Deputy Agency Clerk

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK *Angel Sanders*
DATE MAY 30 2013

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,
Petitioner,

v.

DOH Case Nos. 2011-09782
2011-11371

ALBERTO SANT ANTONIO, M.D.,
Respondent.

VOLUNTARY RELINQUISHMENT OF LICENSE

Respondent Alberto Sant Antonio, M.D., license No. 82484, hereby voluntarily relinquishes Respondent's license to practice medicine in the State of Florida and states as follows:

1. Respondent's purpose in executing this Voluntary Relinquishment is to avoid further administrative action with respect to this cause. Respondent understands that acceptance by the Board of Medicine (hereinafter the Board) of this Voluntary Relinquishment shall be construed as disciplinary action against Respondent's license pursuant to Section 456.072(1)(f), Florida Statutes. As with any disciplinary action, this relinquishment will be reported to the National Practitioner's Data Bank as disciplinary action. Licensing authorities in other states may impose discipline in their jurisdiction based on discipline taken in Florida.
2. Respondent agrees to never reapply for licensure as a physician in the State of Florida.
3. Respondent agrees to voluntarily cease practicing medicine immediately upon executing this Voluntary Relinquishment. Respondent further agrees to refrain from

the practice of medicine until such time as this Voluntary Relinquishment is presented to the Board and the Board issues a written final order in this matter.

4. In order to expedite consideration and resolution of this action by the Board in a public meeting, Respondent, being fully advised of the consequences of so doing, hereby waives the statutory privilege of confidentiality of Section 456.073(10), Florida Statutes, and waives a determination of probable cause, by the Probable Cause Panel, or the Department when appropriate, pursuant to Section 456.073(4), Florida Statutes, regarding the complaint, the investigative report of the Department of Health, and all other information obtained pursuant to the Department's investigation in the above-styled action. By signing this waiver, Respondent understands that the record and complaint become public record and remain public record and that information is immediately accessible to the public. Section 456.073(10) Florida Statutes.

5. Upon the Board's acceptance of this Voluntary Relinquishment, Respondent agrees to waive all rights to seek judicial review of, or to otherwise challenge or contest the validity of, this Voluntary Relinquishment and of the Final Order of the Board incorporating this Voluntary Relinquishment.

6. Petitioner and Respondent hereby agree that upon the Board's acceptance of this Voluntary Relinquishment, each party shall bear its own attorney's fees and costs related to the prosecution or defense of this matter.

7. Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent in connection with the Board's consideration of this Voluntary Relinquishment. Respondent agrees that consideration of this Voluntary

Relinquishment and other related materials by the Board shall not prejudice or preclude the Board, or any of its members, from further participation, consideration, or resolution of these proceedings if the terms of this Voluntary Relinquishment are not accepted by the Board.

DATED this 29 day of May, 2013.

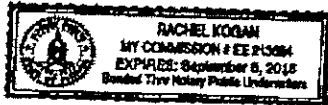
Alberto Sant Antonio
ALBERTO SANT ANTONIO, M.D.

STATE OF FLORIDA
COUNTY OF:

Before me, personally appeared Alberto Sant Antonio, whose identity is known to me by personally known (type of identification) and who, under oath, acknowledges that his signature appears above. Sworn to and subscribed before me this 29 day of May, 2013.

Rachel Kogan
NOTARY PUBLIC

My Commission Expires:



DOH v. Alberto Sant Antonio
Case Nos. 2011-08782 & 2011-11371

3

33527

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v.

CASE NO. 2011-09782

ALBERTO SANT ANTONIO, M.D.,

RESPONDENT.

AMENDED ADMINISTRATIVE COMPLAINT

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

1. The Petitioner is the state agency 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, Respondent was a licensed physician within the State of Florida, having been issued license number ME 82484.

33528