

B) ICD-9-CM Codes

OPR: 216869, 716937, 77001

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)

ICD 426.4 786.5
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 responses)

Unisand Fluoroscopic guidance; 35cm dual lumen 5 French power Picc line

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.	<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.
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Outcome of transfer - e.g., death, brain damage, observation only 24 observation only
 Name of facility to which patient was transferred:
Lakeland Regional Medical Center

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.

Ralph C. Bell (RA36) placement of picc line PRPT 216869 COT 37173
 K. Hearn Burns RN Assistant - APPT 069849 COT 13055
 Jerome Scavone MD - ME 70033
 Anna Applewhite RN 9203265 - Response Team / Blue Team

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)

Patient experienced potential known complication of Picc line insertion with tip fluoroscopically placed at carotid junction.

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

Confirmation/Verification of tip placement.

V.

Ralph C. Bell MD

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

RA 36

LICENSE NUMBER

7/2/14

DATE REPORT COMPLETED

10:50

TIME REPORT COMPLETED

B) ICD-9-CM Codes

ICD-9-CM 97.76 937.77 001

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)

ICD 426.4 786.5

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)

Untrasound / Fluoroscopic guidance; 35cm dual lumen 5 French power Picc line

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>24 observation only</u> Name of facility to which patient was transferred <u>Lakeland 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 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.

Rafael C. Bell (RA36) placement of picc line ABET 276569 CRT 37173
Kathleen Burns RN Assistant - ABET 069849 CRT 13085
Jerome Scavone MD - ME 70033
Annex Applewhite RN 8083215 - RNurse Kam / Blue Kam

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)

Patient experienced potential X-ray complication of Picc line insertion with tip fluoroscopically placed at carotid junction.

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

Confirmation / Verification of tip placement.

v. Rafael C Bell MD RA 36
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
7/2/14 10:50
 DATE REPORT COMPLETED TIME REPORT COMPLETED



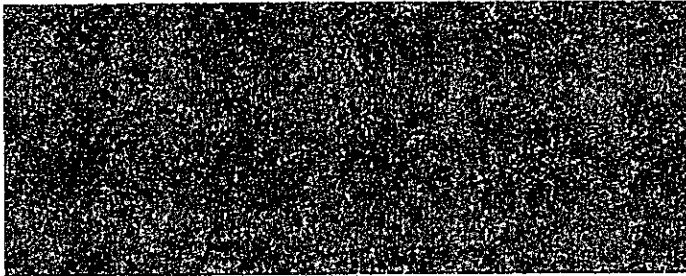
STATE OF FLORIDA
Charlie Crist, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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: American Access Care of Jacksonville Street Address: 800 Lomax St., Suite 100
City: Jacksonville Zip Code: 32204 County: Duval Telephone: 904 353 3664
Name of Physician or Licensee Reporting: Yok Chong License Number & office registration number, if applicable: ME105741 HCC10130
Patient's address for Physician or Licensee Reporting: 700 Lomax St Suite 100 Jacksonville, FL



Age: 31 Gender: Female ☒ Medicaid ☐ Medicare
Date of Office Visit: 7/1/2014
Purpose of Office Visit: Left upper arm AV fistulogram
ICD-9 Code for description of incident: 85.6
Level of Surgery (II) or (III): II

III. INCIDENT INFORMATION

Incident Date and Time: 7/1/2014 1300

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other: Post-discharge

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 was discharged from the facility and then transported by ambulance to Baptist Hospital for pre-existing abdominal swelling. Please see additional sheet for complete narrative.

B) ICD-9-CM Codes

NIA 585.6 459.2
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-89.9)

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

NIA
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 hospital. Outcome of transfer - e.g., death, brain damage, observation only <u>hospitalization</u> Name of facility to which patient was transferred: <u>Baptist Hospital</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 checked="" 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.

Kok Chong MD, Medical Director, ME 105841
Tara Proxix, PT, Facility Manager, CRT 79050
Mark Hamilton, RN, RN939176
Audra Svoboda, RN, RN9291726

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

Lyn Sturte, RN, RN2919502
Prenezine Rhodes, PSC

IV. ANALYSIS AND CORRECTIVE ACTION

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

Pre-existing condition of abdominal swelling

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

Patient required assistance with transportation, an ambulance was called and the patient was transported to Baptist Hospital.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 105841
LICENSE NUMBER

7/18/14
DATE REPORT COMPLETED

1000
TIME REPORT COMPLETED

B) ICD-9-CM Codes

414.01

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)

EKG

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 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:	<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.
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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. Conas ME 716762

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

Morgan Morgan RN 9280257

IV. ANALYSIS AND CORRECTIVE ACTION

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

It states she wasn't feeling good before leaving for appointment. Possible.

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

Took BP, O2sat, EKG. laid patient down on stretcher

V.

SIGNATURE OF PHYSICIAN LICENSEE SUBMITTING REPORT

ME 716762
LICENSE NUMBER

B) ICD-9-CM Codes

43239 43249
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 86-99.9)

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

863.89
Resulting injury (ICD-9 Codes 800-898.9)

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

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital. Outcome of transfer - e.g., death, brain damage, observation only <u>Observation</u> Name of facility to which patient was transferred: <u>Memorial Regional Hospital</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.

Aracelis Valdez, R.N. - RN 9299875
Maria C. Piro, L.P.N. - RN 5212914
Diana Rodriguez, R.N.P. - ARNP 91816672
Mark Lamer, M.D. - ME 0037518

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)

None

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

None

V.

[Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

037518
LICENSE NUMBER

2/18/14
DATE REPORT COMPLETED

4:15 P
TIME REPORT COMPLETED

B) ICD-9-CM Codes

36870

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)

NA

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 hospital.	<input type="checkbox"/> Brain Damage
	<input type="checkbox"/> Spinal Damage
	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
Outcome of transfer – e.g., death, brain damage, observation only	<input type="checkbox"/> Fracture or dislocation of bones or joints
Name of facility to which patient was transferred:	<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.

Avelino Estoesta RN 9180926

Manu Sehgal, MD ME100529

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)

Assessment was conducted according to the standard of practice.

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

EMS was contacted as the PT was complaining of shortness of breath.

V.


SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME100529
LICENSE NUMBER

02/25/2014

1400

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA1030-12/06

Page 2 of 2

B) ICD-9-CM Codes

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

250.00
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"/> 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>MRMC</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.
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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.

Stephanie A. Gilhams - Tsonal 91163741
Kevin Noon ARNP
Asad Qamar MD

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

Cathy Duncan, RN 9214462

IV. ANALYSIS AND CORRECTIVE ACTION

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

hyperglycemia

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

Insulin administered and transported to hospital for observation

V.

Cathy Duncan, RN
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

9214462
LICENSE NUMBER

7/9/14
DATE REPORT COMPLETED

1000
TIME REPORT COMPLETED

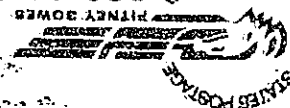
Institute of Cardiovascular
Excellence
4230 SW 49th Rd.
Ocala, FL 34474



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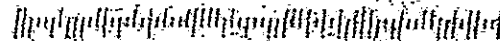
Institute of
Cardiovascular
Excellence

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MAILED FROM ZIP CODE 34474



Dept. of Health
Consumer Sues Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, FL 32399-3275

32399327559



83



Rick Scott, Governor



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
ACCESS CENTER (Q TVGN)

Name of office
NAPLES 34103 COLLIER
City Zip Code County
RAJASINGHE
Name of Physician or Licensee Reporting
AS ABAYE
Patient's address for Physician or Licensee Reporting

2450 GOODLETTE RD N
Street Address
239-643-8794
Telephone
ME86677
License Number & office registration number, if applicable



Patient Identification Number
DIALYR COMPL D/T RENAL DIALYSIS
Diagnosis DEVICE 996.13

92 F
Age Gender
7/3/14
Date of Office Visit
DIALYSIS CATHETER PLACEMENT
Purpose of Office Visit
996.13
ICD-9 Code for description of incident
II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

7/3/14 1730
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)

Following placement of tunneled left
femoral dialysis line catheter, patient
continued to have catheter site bleeding
with ambulation despite 1 hour of
supine bedrest recovery.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

7/10/14 1500

1500
TIME REPORT COMPLETED



86

STATE OF FLORIDA
Rick Scott, Governor

158
RECEIVED
AUG 13 2014
BY: _____

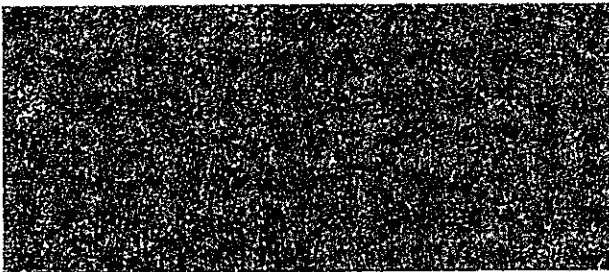
PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Vascular Surgery Associates
Name of office
Tallahassee, FL 32308 Leon
City Zip Code County
Dr. Robert Brumberg
Name of Physician or Licensee Reporting
645 Dover Street, Tallahassee FL 32304
Patient's address for Physician or Licensee Reporting

2631 Centennial Blvd
Street Address
850-877-8530
Telephone
OS9800 OSR925
License Number & office registration number, if applicable



67 male ☐ ☒
Age Gender Medicaid Medicare
7-29-14
Date of Office Visit
Fistulogram with percutaneous intervention
Purpose of Office Visit
E878.8
ICD-9 Code for description of incident
Level II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

7-29-14 1600
Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room
☒ Other, angiography suite

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)

1520 Patient to recovery following percutaneous Intervention for clotted right arm dialysis access.
1610 Patient reports complaints of right hand pain, decreased temp and numbness. Dr. Brumberg notified.
1615 Dr. Brumberg at bedside, order given to transfer patient to TMH for operative Intervention, 1620 Family notified
of recommendation for transfer. 1640 Patient transferred to TMH via EMS in stable condition.

B) ICD-9-CM Codes

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

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

N/A

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 hospital.	<input type="checkbox"/> Brain Damage
Outcome of transfer – e.g., death, brain damage, observation only, operative intervention	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred:	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
Tallahassee Memorial Hospital	<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.

Ashley Matylaszek, RN staff nurse RN 9265206

Julie Angeller, RN staff nurse RN 9305209

Robert Brumberg DO OSA9800

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

Cameron Carroll RPA Lab Manager 11GA1428

Cassie Davis ARNP-C, 9178836 LHRM 5504917

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

88



173



NO

STATE OF FLORIDA
Rick Scott, Governor

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AUG 15 2014
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
Vascular Access Center of Jacksonville
Name of office

Jacksonville 32216 Duval
City Zip Code County

Dr Erin Moore
Name of Physician or Licensee Reporting

Patient's address for Physician or Licensee Reporting

6820 Southport Parkway Suite 1
Street Address

904 296 4106
Telephone

ME 101863
License Number & office registration number, if applicable



72 female ☐ Medicaid ☒ Medicare
Age Gender

7/31/2014
Date of Office Visit

Diagnose hem cath exchange
Purpose of Office Visit

ICD-9 Code for description of incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

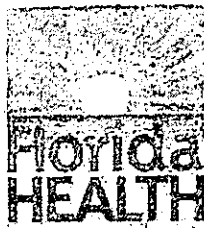
8/3/14 Pt went to Baptist
Incident Date and Time Emergency Room

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

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

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

Please see attached attorney



NO

STATE OF FLORIDA
Rick Scott, Governor

RECEIVED

AUG 14 2014

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT BY:

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

I. OFFICE INFORMATION

Riverside Pain Physicians
Name of office

Jacksonville Bch 32200 Duval
City Zip Code County

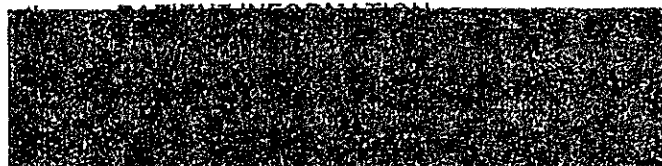
John T. Woeste, MD
Name of Physician or Licensee Reporting

Kathleen Worley, LHRM (5502876)
Patient's address for Physician or Licensee Reporting

1577 Roberts Dr.
Street Address

904-389-1010
Telephone

ME64342 / 05B898
License Number & office registration number, if applicable



720.50 / 719.45
Patient Identification Number

Diagnosis

87 F ☐ Medicaid ☒ Part B Medicare
Age Gender

8-6-2014
Date of Office Visit

Left hip bursa injection.
Purpose of Office Visit

904.9
ICD-9 Code for description of Incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

8/6/2014 1:40pm
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)

Patient was on procedure table - post procedure
patient adjusted herself and fell to the floor
striking her eyebrow and Ant (left).

B) ICD-9-CM Codes

726.50 / 719.45
Surgical, diagnostic, or treatment
procedure being performed at time of
incident (ICD-9 Codes 01-99.9)

E885.9
Accident, event, circumstances, or
specific agent that caused the injury
or event. (ICD-9 E-Codes)

924.9
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>Left prefrontal contusion on forehead</u> Name of facility to which patient was transferred: <u>Baptist Beaches Medical Center</u> <u>1350 13th Ave South</u> <u>Jax Bch, FL 32250</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.

Carolyn Bolack, C-MA

Dr. John Woeste, M.D. 4342

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

Carolyn Bolack, CMA

IV. ANALYSIS AND CORRECTIVE ACTION

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

Patient was not strapped with OR Strap.

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

Fast procedure - 2 clinical staff will be present in the OR to assist with patient transfer to PACU.
All pt. will be secured with OR table straps.

Kathleen J. Wiles, LHRM 5502876

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

8-7-2014

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED 1:06pm



STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

DOH Consumer Service!

AUG 26 2014

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

I. OFFICE INFORMATION

Vascular Access Center of Jacksonville
Name of office

Jacksonville 32216 Duval
City Zip Code County

Dr. Geoffrey Bishop
Name of Physician or Licensee Reporting

Patient's address for Physician or Licensee Reporting

1820 Southpoint Parkway, Suite 1
Street Address

904-296-4106
Telephone

ME 83348
License Number & office registration number, if applicable

6314
Patient Identification Number
Diagnosis

22 Female
Age Gender

8/13/14
Date of Office Visit
Catheter (Dialysis) exchange
Purpose of Office Visit

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

8/13/14 9:35 AM
Incident Date and Time

Location of Incident:
☒ Operating Room
☐ Other

☐ 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)

Please see attached description of incident.

Vascular Access Center

VAC of Jacksonville*
6820 Southpoint Parkway
Suite 1
Jacksonville, FL 32216
P 904-296-4106
F 904-296-3340

"VITALS UPON CHECK IN WERE AS FOLLOWS: BP 130/95, HR 51, RESP 18, O2 SATS 99% ON RA, TEMP 97.0, PT TEARFUL AND ANXIOUS BEFORE AND THROUGHOUT PROCEDURE. PRIOR TO PROCEDURE UNABLE TO DRAW BACK ON CATHETER. PT REFUSING IV STATING, "YOUR NOT GOING TO FIND ANYTHING, I HAVE NO VEINS." DR RISLEY MADE AWARE, ORDERED ANCEF 2G IV, VERSED 1MG IV, AND FENTANYL 50MCG IV ON TABLE TO BE GIVEN. NAME, DOB, PROCEDURE, AND ALLERGIES ON BOARD PROPERLY. TIME OUT PERFORMED BY C MURPHY RN WITH NAME, DOB, ALLERGIES AND PROCEDURE. AS PROCEDURE BEGAN LIDOCAINE WAS USED TO NUMB THE AREA AND CONTRAST FLUSHED. ANCEF THEN GIVEN BY DR RISLEY ALONG WITH VERSED AND FENTANYL THROUGH CATHETER AT 0928. PT ALERT AND ORIENTED ASKING TO BE TOLD STEP BY STEP WHAT WAS GOING ON. THEN AT 0930 BEGAN TO SAY SHE WAS FEELING STRANGE, ADVISED PT THAT SHE WAS GIVEN SEDATION. PT THEN FOLLOWED BY SAYING SHE CANT BREATHE, O2 SATS 99-100% ON 2L NO. AS PROCEDURE WENT ON PT THEN BEGAN TO SAY SHE WAS FEELING NAUSEATED. IT WAS THEN NOTED BY R LOWE RT THAT DR RISLEY AND RT R LOWE HAD ON LATEX GLOVES. PT WAS ALSO MOVING ON TABLE STATING THAT SHE NEEDED TO GET UP BECAUSE SHE FELT SHE WAS "GOING TO THROW UP." DR RISLEY THEN BROKE SCRUB AND APPLIED LATEX Free GLOVES, HE THEN ORDERED 25MG BENADRYL FOR PRECAUTION OF ALLERGIC REACTION, AND 12.5MG OF PHENERGAN FOR NAUSEA. I (WRITER) WENT OUT TO NURSING STATION TO RETRIEVE PHENERGAN FROM MED STOCK, UNSURE IF THERE WAS A VORB. 25MG BENADRYL AND 25MG PHENERGAN WERE THEN PASSED OFF TO DR RISLEY BY R HERNANDEZ RN, AND GIVEN BY DR RISLEY. INITIAL CATHETER NEVER PULLED, AND PROCEDURE NOT COMPLETED. DR RISLEY ORDERED CURRENT CATH TO BE CLEANED AND DRESSING APPLIED FOR PATIENT TO GO TO HOSPITAL AND HAVE PROCEDURE COMPLETED AT HOSPITAL UNDER ANESTHESIA. PT STILL STATING SHE FELT LIKE SHE WAS GOING TO THROW UP AND NEEDED TO SIT UP, NO VOMITING VISUALLY SEEN DURING OR AFTER PROCEDURE. SITE WAS CLEANED AND DRESSED. SAT PT UP AT THAT TIME. PT THEN MOVED TO STRETCHER AND TAKEN TO RECOVERY AT 0932, AT 0933 PT PLACED ON MONITOR IN RECOVERY, VITALS AT THIS TIME WERE AS FOLLOWS: BP 75/68, HR 102, 85% SATS. NON REBREATHAR APPLIED. DR RISLEY NOTIFIED AND IS AT BEDSIDE AT THIS TIME. EMS CALLED AT 0935. POSITIVE PULSE AND PRESSURE. OXYGEN SATS AT 0942 97% WITH NON REBREATHAR MASK, PT UNRESPONSIVE AT THIS TIME. CATH THEN ACCESSED WITH STERILE TECHNIQUE BY CMURPHY RN. 0.4MG NARCAN IV AND 0.5MG ROMAZICON IV ORDERED BY DR RISLEY. VORB BY CMURPHY RN AND GIVEN AT 1000, PER DR RISLEY'S ORDERS. PT RESPONDING TO COMMANDS, BUT VERY COMBATIVE OFF AND ON. VITALS AT 1003 WERE AS FOLLOWS: BP 149/112, HR 110, 98% SATS. VITALS AT 1013 WERE AS FOLLOWS: BP 120/69, HR 104, RESP 18, 99% SATS. PT CONTINUING TO STAY AT BASELING 99% SATS AND STABLE BP. EMS ARRIVED AT 1020. PT TAKEN TO HOSPITAL AT 1025.
DR MANSUR WAS MADE AWARE OF SITUATION BY DR RISLEY.

1530- DR MANSUR WAS CALLED BY S. JOHNSON RN TO FOLLOW UP ABOUT PT. HE STATES THAT HE DID NOT KNOW DETAILS ABOUT THE PATIENT YET, HE HAD NOT SEEN HER, BUT THAT SHE WAS BEING ADMITTED TO ICU AT MEMORIAL HOSPITAL."

CMurphy
Sturgeon center manager



Vascular Access Center is proud to have earned the Joint Commission Seal of Approval.
The Joint Commission Seal of Approval validates Vascular Access Center care standards
and commitment to enhanced patient care.
* Awarding Joint Commission accreditation

B) ICD-9-CM Codes

996.73

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)

NO equipment used

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>Memorial Hospital</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.

<u>Geoffrey Busley MD</u>	<u>MD 83348</u>
<u>Rachel Lowe RT</u>	<u>CRT 63259 AERT 376509</u>
<u>Christy Murphy RN</u>	<u>RN 9287214</u>
<u>Rima Hernandez RN</u>	<u>RN 9258205</u>

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)

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

V. Lynette M. Hays RN Certified RN 9228682
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
820114 930800
 DATE REPORT COMPLETED TIME REPORT COMPLETED



STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

DOH Consumer Services

AUG 26 2014

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

I. OFFICE INFORMATION

Vascular Access Center of Jacksonville
Name of office

Jacksonville 32216 Duval
City Zip Code County

Dr Moore
Name of Physician or Licensee Reporting

Patient's address for Physician or Licensee Reporting

6820 Southpoint Parkway Suite 1
Street Address

904 296 4106
Telephone

MC 101863
License Number & office registration number, if applicable

II. PATIENT INFORMATION

ESL
Patient Identification Number
Diagnosis

8/14/14
Date of Office Visit
left arm fistulogram with PTA/thrombectomy
Purpose of Office Visit
IT
ICD-9 Code for description of incident
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

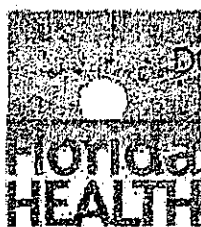
8/14/14 1425
Incident Date and Time

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 description of incident.



DOH Consumer Services

STATE OF FLORIDA
Rick Scott, Governor

AUG 27 2014

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

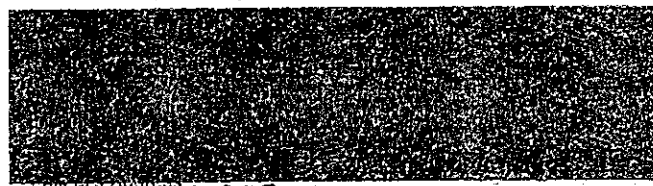
92

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bld C75
Tallahassee, Florida 32399-3276

I. OFFICE INFORMATION

American Access Care of Miami, LLC
Name of office
Miami 33156 Miami Dade
City Zip Code County
Dr. Jose Ramirez
Name of Physician or Licensee Reporting
Same as Above
Patient's address for Physician or Licensee Reporting

9200 S. Dixie Blvd Suite 101
Street Address
305 670 1044
Telephone
ME86739 OSR 672
License Number & office registration number, if applicable



MRN 4021342
Patient Identification Number
443.9
Diagnosis

6740 male ☐ Medicaid ☐ Medicare
Age Gender
8/18/2014
Date of Office Visit
Anticoagulation
Purpose of Office Visit
II
ICD-9 Code for description of Incident
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

8/18/2014 1745
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)

Once procedure was completed sheath to right groin was not able to be removed. Hematoma was noted around access site. Pressure was held manually. Blood pressure decreased to 90 mmHg systolic. IV fluids administered. Patient remained APOX3. EMS was called and patient was transferred to Kendall Hospital. Sheath removed and exploratory surgery by Dr. Ramirez, R.T. was transported with stable vital signs. Dr. performed surgery at the hospital and patient remained in stable condition. Patient was discharged without further incident on 8/22/14

B) ICD-9-CM Codes

15116

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>Surgery in progress</u> Name of facility to which patient was transferred: <u>Vanderbilt Regional Hospital</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,
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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.

<u>Jose Ramirez MD</u>	<u>ME 86739</u>	<u>305 1070 1044</u>
<u>Diana Kokule RN</u>	<u>LVN 005 5454</u>	<u>305 - 670 1044</u>
<u>Madelaine Menden</u>	<u>SN 606 ASSISTANT</u>	<u>305 - 670 1044</u>
<u>Yusuf Pley PA</u>	<u>PA 9106104</u>	<u>305 1070 1044</u>

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)

Possible Risk Factor with this type of Procedure & Bleeding from groin puncture site due to Amblyophtalmia & Brain tumor use

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

Incident was handled as per protocol no further actions taken

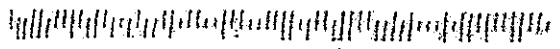
V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED



323993275

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

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2222 S. Harbor City Blvd., 6th Floor
Melbourne, Florida 32901



Vascular Specialists

of Central Florida, Inc.

Vascular Surgery Endovascular Surgery

Charles S. Thompson, M.D., F.A.C.S.

Jan M. Wesley, M.D., F.A.C.S.

Adam B. Levitt, M.D., F.A.C.S.

Michael J. Muchlberger, M.D.

Shonak B. Patel, M.D.

Aubrey A. Harman, ARNP

80 W. Michigan Street
Orlando, FL 32806
Telephone 407-648-4323
Fax 407-839-1493

1920 Don Wickham Drive
Suite 120
Clermont, FL 34711
Telephone 352-241-7585
Fax 352-241-7595

7460 Doc's Grove Circle
Orlando, FL 32819
Telephone 407-648-4323
Fax 407-839-1493

10000 W. Colonial Drive
Suite 483
Orlando, FL 34761
Telephone 407-648-4323
Fax 407-839-1493

The Vascular Laboratory



80 W. Michigan Street
Orlando, Florida 32806
Telephone 407-648-5499
Fax 407-839-1493

1920 Don Wickham Drive
Suite 120
Clermont, Florida 34711
Telephone 352-241-7585
Fax 352-241-7595

was no evidence of any bleeding at the level of the groin nor the pelvis on examination prior to discharge. Although she was given intra-arterial doses of vasodilators, the short half-life of these medications should have rendered them inert by the time of discharge. It is probable that she had a sudden myocardial event. Although she complained of no chest pain and her resting rhythm strip was the same pre-and postoperatively, we know that patients with her comorbidities are at a higher risk for sudden cardiac death. I am unsure of anything we could have done differently to change her course.

B) ICD-9-CM Codes

<u>724.02</u>	<u>780.2</u>	<u>724.02</u>
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-Code)	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)

Patient tolerated procedure well and was in recovery when incident occurred

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>Florida Hospital Heartland</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. Ashok Sami ME 35635 doctor who performed procedure
Angel Love-Smyth RN 1325251 LPN in the procedure room
Brittany Green RN 5174205 LPN who assisted in recovery
All can be contacted at 863-385-2222

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

Veronica Trujillo PA 9106715 863-385-2222
Ranjeeta Krishnasdas PA 9102350 863-385-2222

IV. ANALYSIS AND CORRECTIVE ACTION

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

Incident most likely due to the fact that the patient did not eat morning of procedure which caused him to become dizzy and nauseated

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

Patient teaching on eating before coming in to have an epidural injection.

V. Ashok Sami ME 35635
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

Angel Love-Smyth LPN PN 1325251

B) ICD-9-CM Codes

V67.00 (POST OP)

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)

996.73

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)

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: _____	<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.
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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.

D. MOREAU, RN RN 2985232

C. RUTER, RN RN 9335563

M. DEROSA, MA

H. RAJASINGHE, MD MEB101077

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

IV. ANALYSIS AND CORRECTIVE ACTION

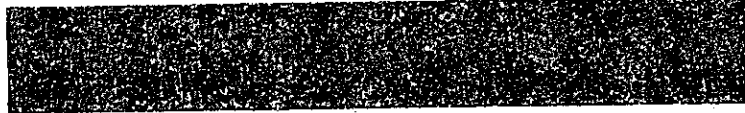
A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Renal failure & uremia

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

FMT transfer electively to NCH for overnight observation with hemostatic dressing.

159



SEP 09 2014

STATE OF FLORIDA
Rick Scott, Governor

ND

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

BY:

93

SUBMIT FORM TO:

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

OFFICE INFORMATION
Vascular and Spine Institute

Name of office, miqmi 33190 Miami Dade
City Zip Code County

Oscar Sosa, M.D.
Name of Physician or Licensee Reporting

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

7887 N. Kendall Dr #210
Street Address

305 598-1555
Telephone

OSR 718
License Number & office registration number, if applicable



Patient's Address #12784
Patient Identification Number 454.8 / 459.81 / 729.5
Diagnosis

8/14/2m male ☐ Medicaid ☒ Medicare
Age Gender

8/21/14
Date of Office Visit

endovascular ablation
Purpose of Office Visit

780.2 (near syncope)
ICD-9 Code for description of incident

level 1
Level of Surgery (I) or (II)

III. INCIDENT INFORMATION

8/21/14 @
Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room
☐ Other Emergency 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)

After a radio frequency ablation of a large incompetent perforator in the right posterior thigh, which was performed without incident, patient stated that he was not feeling well. His blood pressure did reveal significant hypertension of 220/140. Patient is a known hypertensive, but stated that he had not taken his blood pressure medication as he was indicated to do. He was given 0.1 mg of clonidine orally at the Vascular and Spine Institute and his blood pressure did decrease to 180/100. Patient was stable with normal respiratory rate and normal pulse. Despite being stable, patient wished to be transferred by ambulance to Baptist Emergency Room immediately for evaluation. Patient has a history of bleeding ulcer and was convinced that he was suffering from anemia related to that bleeding ulcer. Dr. Sosa attempted to reassure him that there is no evidence of anemia or significant blood loss by his vital signs but he insisted that he required immediate evaluation. He was then transferred to the Baptist Emergency Room via ambulance per his request.

B) ICD-9-CM Codes

36475
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

none
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)

none

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 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:	<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.
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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.

Oscar Sosa, M.D. (ME80319) physician
Eva Ramos, R.N. (RN9248026) nurse
Arthurene Rodriguez - N/A - assistant

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)

patient anxiety over history of bleeding ulcer

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

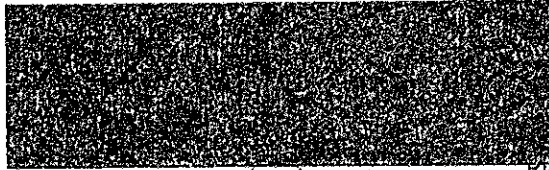
none needed - patient was responsible for request to be transferred

V.

[Signature] ME80319
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
8/29/14 1400
 DATE REPORT COMPLETED TIME REPORT COMPLETED

95

158



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 C75
Tallahassee, Florida 32399-3278

SEP 11 2014

I. OFFICE INFORMATION

First Coast Cardiovascular Institute

Name of office

Jacksonville

FL

Duval

City

Zip Code

County

Vaqar Ali, MD ME93151

Name of Physician or Licensee Reporting

FCCI Cath Lab

Patient's address for Physician or Licensee Reporting

3900 University Blvd. S.

Street Address

904-493-3933 ext 1054;1065

Telephone

n/a

License Number & office registration number, if applicable

II. PATIENT INFORMATION



Peripheral Vascular Disease

Diagnosis

56

Male

☒

☐

Age

Gender

Medical Medicare

08/22/2014

Date of Office Visit

Revascularization

Purpose of Office Visit

443.9

ICD-9 Code for description of incident

II

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

08/22/2014 1630

Incident Date and Time

Location of Incident

☐ Operating Room

☒ Other Cath Lab

☐ 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)

After successful recanalization of totally occluded Right Superficial Femoral artery, the patient was brought to the recovery area. He continued to complain of abdominal pain. While the patient's vital signs remained stable he did experience nausea and vomiting. The patient was transferred via ambulance to Memorial Hospital of Jacksonville where a stat CT of the abdomen revealed a retroperitoneal bleed. He remained in the hospital 48hrs where his H/H was closely monitored. He was then released to home care with no residual complications.

35



STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
SEP 10 2014

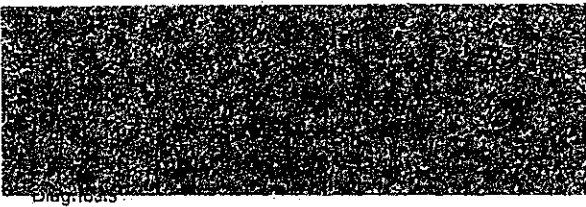
SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

First Coast Cardiovascular Institute
Name of office
Jacksonville FL Duval
City Zip Code County
Yazan Khatib, MD ME85393
Name of Physician or Licensee Reporting
FCCI Cath Lab
Patient's address for Physician or Licensee Reporting

3900 University Blvd, S.
Street Address
904-493-3333 ext 1054;1055
Telephone
n/a
License Number & office registration number, if applicable

II. PATIENT INFORMATION



71 Age Male ☐ Gender ☒ Medical ☒ Medicare
08/25/2014 Date of Office Visit
Revascularization Purpose of Office Visit
447.9 ICD-9 Code for description of incident
II Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

08/26/2014 2240
Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room
☒ Other Cath Lab

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

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

Patient developed hematoma status post revascularization of Right lower extremity. Patient was subsequently transferred to Memorial Hospital of Jacksonville via ambulance in stable condition for further evaluation and observation. He was discharged home in 24hrs.

73



STATE OF FLORIDA
Rick Scott, Governor

RECEIVED
SEP 10 2014
BY:

Florida
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

97

I. OFFICE INFORMATION

Lifeline Vascular Access
Name of office
Orlando FL 32806 Orange
City Zip Code County
Donna Lawrence RN
Name of Physician or Licensee Reporting

1511 Sligh Blvd Suite A
Street Address
407 472 5120
Telephone

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient
Patient
Patient
Diagnosis ESRD

66 male ☐ Medicaid ☐ Medicare
Age Gender
8/25/14
Date of Office Visit
vascular access dysfunction
Purpose of Office Visit
86.03
ICD-9 Code for description of incident
Level of Surgery (II) or (III) (II)

III. INCIDENT INFORMATION

8/25/14 1034
Incident Date and Time

Location of Incident:
☐ Operating Room ☐ Recovery Room
☐ Other Procedure Room

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

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

Near conclusion of procedure patient experienced an episode
apnea & unresponsive lastly approximately 30 sec,
Heart Rate dropped into 50's no medication was administered
during the procedure. Oxygen initiated, airway
opened, V's monitored, B.L.S initiated & patient
regained consciousness. EMS arrived &
transported patient to local Emergency Room

Two hours later the patient's wife calls to report he

was "doing fine", but would stay 24°
on 8/28/14 patient return to center for a procedure
and tolerated without incident.

B) ICD-9-CM Codes

996.73
Surgical, diagnostic, or treatment
procedure being performed at time of
incident (ICD-9 Codes 01-89.9)

786.03
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 of the patient to a hospital.	<input type="checkbox"/> Brain Damage
Outcome of transfer - e.g., death, brain damage, observation only <u>for 24 hours</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred: <u>Florida Hospital Orlando</u>	<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. Lazaro Delgado
Donna Lawrence RN
Sean Ann RT
Michael Lowman S.T.

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)

during procedure vocal nerve might have been stimulated leading to bradycardia

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

continue to monitor patient, vitals monitor readings throughout. Incident was handled appropriately.

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)

NA

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>Walter 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.

Danny Quisenberry MD
Danny Quisenberry MD
Ken Brown MD
Dr. Schumacher - anesthesiologist

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)

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

Change anesthetic table to standard
See above

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 6397.3
 LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED



STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SEP 18 2014

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

OFFICE INFORMATION

Name of office
City
Zip Code
County
Name of Physician or Licensee Reporting
Patient's address for Physician or Licensee Reporting

Street Address
Telephone
License Number & office registration number, if applicable

PATIENT INFORMATION

Patient Name
Patient's Address
Patient Identification Number
Diagnosis

Age
Gender
Medical Insurance
Date of Office Visit
Purpose of Office Visit
ICD-9 Code for description of incident
Level of Surgery (II) or (III)

INCIDENT INFORMATION

Incident Date and Time

Location of Incident:
☐ Operating Room
☐ Other
☒ 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)

Pt Ambulate to assist to bathroom. Pt was checked in within 5 min and found pt slipped over toilet and had vomited. Pt was breathing with pulse present. Pt was placed on floor, manual pressure to left groin due to hemorrhage. Ambu bag from crash cart was used to help the patient breathe. Placed in cardiac monitoring. Dr. James Monahan and came in. Pt hypoxic, 12 long Tr gas. SpO2 board placed under pt, was transferred to stretcher. Taken to pt's room. Pt conscious, responding to verbal stimuli. Placed in cardiac

monitors. V.S. taken every 5 min. Pt. remains hypotensive and tachycardic. Manual pressure to left groin site due to hematoma. Dr. Garner evaluates pt and orders that pt. be sent to hosp for observation and monitoring. Hematoma has resolved itself at time of discharge to EMS for hospital admission. Pt. was hypotensive, Nauseated and had vomited prior to discharge. Pt. remains hypotensive and the Nausea and Vomiting had subsided, Hematoma in left groin has resolved at discharge.

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)

Crash Cart, Ambu Bag, 100% NACI, Sling Board, Extra monitor
Blood pressure cuff

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 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>Observation</u> Name of facility to which patient was transferred: <u>West Marine Hospital</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 checked="" 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.

Tammy Drinkwater RN -

Dani Yanez - RN - Ambu pt.

Eric Heesh - RN - placed EKG on pt

John Salome - RN - held manual respiration to face

Toni Sandlin - RN - assist in giving meds

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

Sonya Bahr RN - assist in monitoring

Lisa Willis RN - assist in getting supplies needed

IV. ANALYSIS AND CORRECTIVE ACTION

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

Pt. was hypotensive with Nausea. Dr. Danner advised and ordered Pt. to be transferred to West Marine Hosp for observation

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

Pt. was transferred to West Marine Hosp via EMS and admitted for observation

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

B129114

1300

DATE REPORT COMPLETED

TIME REPORT COMPLETED



ND

98

STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SEP 13 2014

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

I. OFFICE INFORMATION

Name of office: Spine Coast Cancer Center
City: Titusville Zip Code: 32796 County: Brevard
Name of Physician or Licensee Reporting: Ashish Dalal MD

Street Address: 490 N Washington Ave
Telephone: (321) 268 4200
License Number & office registration number, if applicable: ME0085152

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Information]
Patient Identification Number: 75477
Diagnosis: Breast CA

Age: 91 Gender: F ☐ Medicaid ☒ Medicare
Date of Office Visit: 9/9/14
Purpose of Office Visit: Follow-up on
ICD-9 Code for description of Incident:
Level of Surgery (II) or (III):

III. INCIDENT INFORMATION

Incident Date and Time: 9/9/14 ~ 11:13

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other: MA station

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

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

See attached

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)

Fetal transfer cannula Part # 2270-BAN 0230LL

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 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>Observation only</u> Name of facility to which patient was transferred: <u>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: <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient 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.

Daniel M Zeichner, MD - ME 99070
Angel Sepulveda CRNA - ARNP 3967602
Angel Colon ST
Coral Kaya, ST

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.

06/10/14
 DATE REPORT COMPLETED

10:26 AM
 TIME REPORT COMPLETED

ME 99070
 LICENSE NUMBER

Continued from page 1

Patient returned to facility on 06/07/2014 for follow-up evaluation. Patient described herself as feeling weak but ambulatory. Although patient did not present the final written diagnosis or impression from the attending physicians, she relayed that the prognosis indicated no long term or permanent adverse health issues as a result of this incident.

Patient is currently receiving no treatments but is scheduled for periodic follow-ups with a cardiologist.

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)

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 Name of facility to which patient was transferred: <u>Parrish 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.
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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.

Ashish Datta MD ME 0085152
Jennifer Bomba MA

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

PH's son

IV. ANALYSIS AND CORRECTIVE ACTION

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

R/O STROKE

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 0085152
 LICENSE NUMBER

DATE REPORT COMPLETED

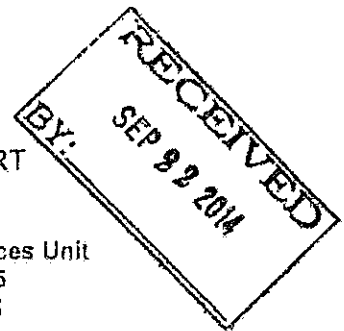
TIME REPORT COMPLETED



STATE OF FLORIDA
Rick Scott, Governor

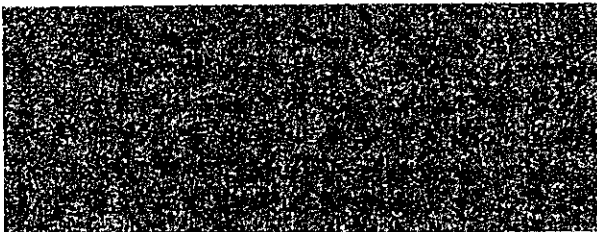
PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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



OFFICE INFORMATION
Institution of Cardiovascular Excellence 4730 SW 49th rd.
Name of office
Ocala 34474 Marion
City Zip Code County
Dr. Solanki
Name of Physician or Licensee Reporting
Street Address
(352) 854-0681
Telephone
OSR 820
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting



Diagnosis

66 male
Age 9/9/14 Gender ☐ Medicaid ☐ Medicare
Date of Office Visit
Purpose of Office Visit LHC, LV gram
93460
ICD-9 Code for description of incident
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

9/9/14
Incident Date and Time

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other pt returned from 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)

9/9/14 @ 1315 pt discharged from Ice cath lab in stable condition. Then on 9/9/14 @ 11025 patient returned to cath lab (Ice), clo some discomfort to his (L) groin. Pt became hypotensive, diaphoretic, + pale. (L) groin area noted to have a hematoma at the iliac crest down to the upper thigh area. IV fluids were started + manual pressure held to hematoma. orders obtained at this time for pt to be transported to OKMC. Fern-stop placed to (L) groin area + pt transported to OKMC via EMS. IV + Fern-stop in place. Buterap pedal pulses palpable at time of transport. Spine some rx

★ See attached detailed documentation ★

B) ICD-9-CM Codes

93960

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

E879.0

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

998.12, E879.0

Resulting injury (ICD-9 Codes 800-999.9)

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

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital. Outcome of transfer - e.g., death, brain damage, observation only Name of facility to which patient was transferred: <u>OKMC</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.

Stacey Newsome RN RN 9360980
 Tammy Brinkman RRTS
 Karpesh Shankar MD
 Steven Rhoads RRTS
 Lisa Wills, RN

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

Lisa Wills RN

IV. ANALYSIS AND CORRECTIVE ACTION

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

hematoma to L groin area

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

hem-stop applied & pt transported to OKMC for observation

V. Stacey Newsome RN RN 9360980

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

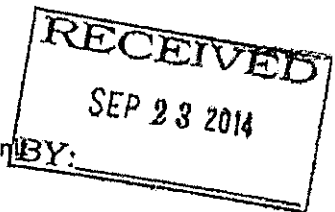
TIME REPORT COMPLETED

100



STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

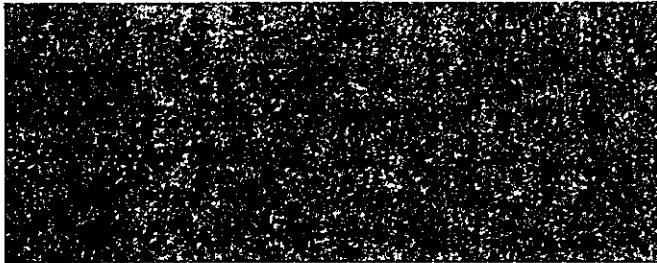


SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Strong Health Network, PLLC
Name of office
Miami 33126 Miami-Dade
City Zip Code County
Manuel A. Gonzalez, M.D.
Name of Physician or Licensee Reporting

815 NW 57 Ave. Suite 130
Street Address
305-266-2286
Telephone
ME110782 052 # 923
License Number & office registration number, if applicable



Patient Identification Number
PAD with crushing pain 440.22
Diagnosis

58 Female ☐ ☒
Age Gender Medicaid Medicare
9-12-14
Date of Office Visit abdominal aortogram, lower extremity
Purpose of Office Visit angiogram and endovascular intervention with
E878.8 atherectomy and balloon
ICD-9 Code for description of incident angioplasty.
II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

9-12-14 1:25 PM
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)

See attached.

B) ICD-9-CM Codes

39.50 Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	E278.8 Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	997.2 Resulting Injury (ICD-9 Codes 800-999.9)
---	--	---

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

None.

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>infusion of TPA and surgery</u> Name of facility to which patient was transferred: <u>Jackson Memorial Hospital</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.

Manuel A. Guzman, M.D. License # ME110782 - physician performing procedure
Jose C. Pineda, RN - License # RN9245916 - Anesthesia
Lysannet Talavera, RN - License # RN9390848 - recovery

All can be reached at 305-266-2286.

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

Albert Gonzalez - surgical assistant
Ormer Meliz - surgical assistant

can be reached at 305-266-2286.

IV. ANALYSIS AND CORRECTIVE ACTION

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

Patient had recurrent Stent thrombosis on presentation. We were able to re-open her left leg flow into mid-thigh area. However, there was no flow distal to this. We decided to transfer her to the hospital for TPA infusion and possible vascular surgery.

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

We identified a medical issue that cannot be treated on an outpatient basis and we decided to transfer the patient to the hospital for TPA infusion and possible vascular surgery.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT <u>[Signature]</u>	LICENSE NUMBER <u>ME110782</u>
DATE REPORT COMPLETED <u>9-18-14</u>	TIME REPORT COMPLETED <u>10:05 PM</u>

- [REDACTED]
- [REDACTED] is a 58 year old female with a history of severe PAD with diffuse disease and multiple previous endovascular interventions. She had recurrent left SFA in-stent thrombosis. On the first occasion, after reopening the stent, we switched her from Plavix to Brillinta twice a day, suspecting Plavix resistance. On the second occasion, after opening the stent, we added Xarelto 20mg twice a day to the previous regimen. Unfortunately, she presented with a third in-stent thrombosis of the left SFA. This time we reopened again the common femoral, SFA, popliteal and proximal tibial vessels; however, there was still no flow into the distal tibial vessels despite balloon angioplasty and aspiration thrombectomy. I decided to transfer the patient to Jackson Memorial Hospital for TPA (thrombolytic) infusion and consultation with vascular surgery for possible atherectomy or bypass.

Corrective or Proactive Actions:

- I called the emergency department and discussed the case with the emergency physician. Furthermore, I discussed the case with the vascular surgeon, Dr. Keith Jones. The patient indeed was admitted to the hospital, received TPA infusion and had surgery the next day. Up to this point the patient is recovering well.

B) ICD-9-CM Codes

74178 urogram c & s

E947.8

995.00

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 Siemens Volume Zoom; Liebel CT 9000 ADV Injector; 200ml syringe(800099); 20gx1" winged infusion set(381533) Isovue 300/100ml(131535) Lot # 3K12949 Expiration date: 10/16

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 checked="" 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 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
Physicians Regional Medical Center	<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.

Kathleen Murphy: State license: CRT48112. ARRT: 271737
Gail Nesmith: State license: CRT55455. ARRT: 104653
Kevin Wood: State license: CRT55881. ARRT: 287415
Robin Bernstein: State license: CRT72713. ARRT: 161648

Sarah Quinn: State license: CRT86655 ARRT
ARRT: 529929

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)**

Anaphylactic reaction to Isovue contrast.

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

None

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME101126

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

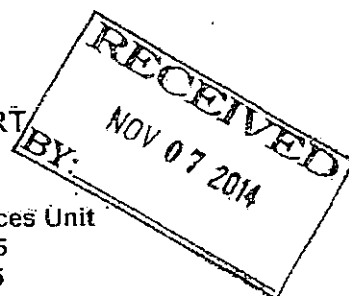
DH-MQA1030-12/06

Page 2 of 2



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 C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Radiology Regional Center

Name of office

Fort Myers 33919 Lee

City Zip Code County

Cyrus Anderson M.D.

Name of Physician or Licensee Reporting

3660 Broadway, Fort Myers, FL 33901

Patient's address for Physician or Licensee Reporting

6140 Winkler Road

Street Address

239-489-4426

Telephone

ME101126

License Number & office registration number, if applicable

84

Age

F

Gender

☐

Medicaid

☒

Medicare

10/16/2014

Date of Office Visit

CT Virtual Colonoscopy

Purpose of Office Visit

74261

ICD-9 Code for description of incident

N/A

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10/16/2014 10:00 am

Incident Date and Time

Location of Incident:

☐ Operating Room

☐ Recovery Room

☒ 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)

Air was insufflated to patient tolerance and CT of the abdomen and pelvis was performed without intravenous contrast in the prone and supine positions. Upon reading the examination it was noted that patient had a large volume of pneumoperitoneum, initially presumed to be diverticular rupture. The patient and referring physician were immediately called. [REDACTED] was contacted and surgical consult by Dr. Mon overnight. Upon surgical exploration Dr. Mon determined this to be a serosal tear at the cecum and ileocectomy was performed. Patient recovered well from the procedure.

B) ICD-9-CM Codes

74261 CT Colonography

E70-8

863.50

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)

GE VCT 64 slice CT Scanner, Air bulb insufflator (Item # EZE9525) One shot cuff inflator (EZE9529) Enema Tip (EZE8816) Enema kit (EZE920)

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 type="checkbox"/> Any condition that required the transfer of the patient to a 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
Health Park Medical Center	<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.Brianne Macpherson: ARRT: 469106 State license: CRT78853
Jackie Thibeau: ARRT: 184718 State license: CRT75459**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)**

Serosal tear

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

None required

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME101126

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA1030-12/06

Page 2 of 2

B) ICD-9-CM Codes

443.9

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

E879.9

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.	<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 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 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.

Vaqr Ali MD ME93151; Jason Cook RRT RT9160; Meagan Jones RN 9292362; Brian Wilsey RRT RT488
Janie Jenkins RN 9242170

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 OF PHYSICIAN/LICENSEE SUBMITTING REPORT

9/03/2014

DATE REPORT COMPLETED

1622

TIME REPORT COMPLETED

ME85393

LICENSE NUMBER

DH-MQA1030-12/06

Page 2 of 2



STATE OF FLORIDA

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

Vascular & Interventional Pavilion
Name of office Street
St Pete 33713 Pinellas
City Zip Code County
Donna Nudbi MD NE100033
Name of Physician or Licensee Reporting
Physician's Address: 3300 38th Ave N, St Petersburg FL 33713
Patient's address for Physician or Licensee Reporting

3300 38th Ave N
Address
727 827 2993
Telephone
OSR 933
License Number & office registration number, if applicable

[Redacted]
996.13 / Other complication of renal
Diagnosis ICD-9 dialysis device, implant, graft
Level

8/6 Male
Gender Male
of Office Visit 08/20/14 LUE numbers
of Office Visit 996.13
Code for description of Incident Level II
of Surgery (II) or (III)

III. INCIDENT INFORMATION

08/24/2014
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

255A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)
See attached sheet.

B) ICD-9-CM Codes

36147/88.40
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

996.73
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)

8x4mm Nestar embolization coils (2),

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <u>Rep 320</u> <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>until retrieval attempt</u> Name of facility to which patient was transferred: <u>Larap 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.

Surgeons: Chaina Wilk MD / ME106633, Niechia Escob MD / ME102023
Rolando Paz - / Rad Tech CRT 81287, Sandy Norton / RN9379678
May locate @ VIP office / State 727 8272993, Dr. Escob cell # 502-353-6164
Brent Zoba CRT 82506

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

Jackie Birds RN9294542, Brian McElish Went Rep, Cell # 81341671625
Clinical Manager 352650221

IV. ANALYSIS AND CORRECTIVE ACTION

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

See attached sheet

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

See attached sheet

V.

ME106633
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
09/09/2014
DATE REPORT COMPLETED
1900
TIME REPORT COMPLETED

ME106633
LICENSE NUMBER

STATE OF FLORIDA PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

III. INCIDENT INFO

A). DESCRIBE CIRCUMSTANCES OF THE INCIDENT (NARRATIVE)

During Fistulogram of LUE (with plan to embolize by coiling 2 large collateral vessels) and after Thrombectomy of brachial arterial thrombus coiling was performed. First coil placed then second coil placed. Then a migration of first coil presented with migration of second coil shortly thereafter into right atrium. Attempt to retrieve coil unsuccessful at this time. [REDACTED] transferred to recovery area for observation while Cook & Merit Medical reps obtained retrieval devices for coils. Patient tolerated procedure well with no cardiac events or apparent complications. [REDACTED] transported to recovery area with RN for close 1:1 observation. Patient tolerated recovery observation period well and without complications.

Second attempt at coil retrieval with larger ensnare device brought to office by Merit Medical rep was unsuccessful. [REDACTED] tolerated this procedure well also without complications. Patient then transported to LMC for close observation until next morning for final attempt in OR with Cook coil retrieval device from Cook Rep as well as assistance from Interventional Cardiologist.

B). ICD-9- CM CODES

36147/88.70: Fistulogram/ Arteriography Using Contrast Material, Unspecified Site.

996.73: Other complications due to renal dialysis device, implant, and graft.

IV. ANALYSIS AND CORRECTIVE ACTION

A). ANALYSIS (APPARENT CAUSE) OF THIS INCIDENT.

Migration of coils into right atrium without cardiac events or apparent complications to patient stable condition. Unable to retrieve coils with ensnare device by Merit Medical. Patient admitted to hospital for close observation at higher level of care as well as consult with Interventional Cardiologist and intervention with Cook Medical coil retrieval device.

B). DESCRIBE CORRECTIVE OR PROACTIVE ACTION(S) TAKEN.

Coil retrieval device used was un-detachable. Now we use a detachable retrieval device in office if we need to do a retrieval. We also have coil retrieval device in office for immediate use instead of depending on vendor reps to provide these types of supplies.

Dr Nwobi found evidence based article stating that retrieving migrated coils is not as imperative as previously thought. This peer reviewed endovascular medical article states that no harm done with not retrieving coils that migrate into heart.

RECEIVED

OCT 10 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 C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Institute of Cardiovascular
Name of office Excellence
Ocala 34414 Marion
City Zip Code County
Dr. Qamar
Name of Physician or Licensee Reporting
4730 SW 49th Rd - Ocala
Patient's address for Physician or Licensee Reporting

4730 SW 49th Rd
Street Address
352-854-0681
Telephone
OSR 820
License Number & office registration number, if applicable

[Redacted]
Patient Identification Number
hematoma
Diagnosis

75 Female
Age Gender
9/26/14
Date of Office Visit
2nd SFA, ATH, PTA, Stent
Purpose of Office Visit
440.21
ICD-9 Code for description of incident
11
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

9/26/14 1550
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)

Patient returned to recovery after Right mid SFA- Athrectomy, PTA, + Stent. Hematoma noted to Left femoral artery cath site. Manual pressure held to LFA site x 10 minute, area noted to be soft after tx. Hematoma returned and pt. was tx c a fem-stop to the LFA @ 110 mmHg. Pt then given Protamine 30mg IV stat to assist c coagulation. Pt became hypotensive + 1 liter placed in trandelenburg, NaCl was given bolus + Atropine 0.5mg was given to stabilize the pt. While EMS was called for an emergency transport to West Marion. Pt. was transported c patients consent via stretcher. 8mlwome RW

B) ICD-9-CM Codes

93460

E879.0

998.12, E879.0

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"/> 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>observation only</u> Name of facility to which patient was transferred: <u>West Marion Hospital</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.

Stacey Newsome RN, Lisa Wells RN
Kimberly McKenzie RN
Kathy Duncan RN
Asad Qamar RN

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)

hematoma, hypotension

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

Manual pressure, femStop, Protamine, Atropine, NACL, pt
Placed in Trendelenburg + EMS transport to West Marion

V.

Stacey Newsome

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

9/29/14

DATE REPORT COMPLETED

TIME REPORT COMPLETED



Rick Scott, Governor

OCT 13 2014

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

Advanced Imaging and Interventional Institute
Name of office

Clearwater 33761 Pinellas
City Zip Code County

Dr. Gerald Niedzwiecki
Name of Physician or Licensee Reporting

1800 Pine Hill Dr, Safety Harbor, FL
Patient's address for Physician or Licensee Reporting

2730 McMullen Booth Rd
Street Address

727-791-7300
Telephone

ME 70649 OSR 521
License Number & office registration number, if applicable

II. PATIENT INFORMATION



729.5 440.22 443.9
Diagnosis

81 F
Age Gender
09-30-2014
Date of Office Visit
Medicaid Medicare

Angiogram with Angioplasty
Purpose of Office Visit

ICD-9 Code for description of incident

11
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

9-30-14 1505
Incident Date and Time

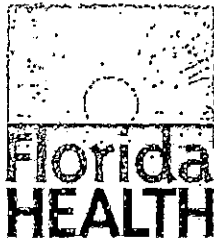
Location of Incident:
☐ Operating Room ☒ Recovery Room
☐ Other

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)

Pt admitted for angiogram and angioplasty for right leg pain. The patient was prepped for the procedure and the procedure was successfully completed. Upon completion of the procedure, a percutaneous closure device was used to obtain hemostasis. This device was not successful and hemostasis was obtained with standard manual compression. During this process, the pt. developed a groin hematoma and prolonged manual compression was applied. Pt transferred to recovery where she was kept on bedrest for 5 hours. Ultrasound of groin showed hematoma with no active bleeding and no pseudoaneurysm. Pt had an uneventful recovery except her BP was stable but below



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 C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office _____
City _____ Zip Code _____ County _____
Name of Physician or Licensee Reporting _____
Patient's address for Physician or Licensee Reporting _____

Street Address _____
Telephone _____
License Number & office registration number, if applicable _____

II. PATIENT INFORMATION

Patient Name _____
Patient's Address _____
Patient Identification Number _____
Diagnosis _____

Age _____ Gender _____ ☐ Medicaid ☐ Medicare
Date of Office Visit _____
Purpose of Office Visit _____
ICD-9 Code for description of incident _____
Level of Surgery (II) or (III) _____

III. INCIDENT INFORMATION

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)

her normal. IV fluids were administered. After 5 hours pt was assisted to sitting position with minimal dizziness. Upon standing with assistance, she became dizzy and had a brief loss of consciousness. She was quickly returned to her stretcher. Pt. regained consciousness spontaneously. IV fluids were administered and Oxygen re-applied. Pt vitals were stable but pt could not be discharged home. Ems was called to transfer pt to the ER for evaluation. Pt was awake, alert & oriented upon transfer. She denied any pain or discomfort.

B) ICD-9-CM Codes44.3.9

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

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

Resulting injury (ICD-9 Codes 800-999.9)

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

(Use additional sheets as necessary for complete response)

none**D) Outcome of Incident (Please check)**

<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"/> A procedure to remove unplanned foreign objects remaining from surgical procedure.	** if it resulted in:
<input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.	<input type="checkbox"/> Death.
Outcome of transfer – e.g., death, brain damage, observation only _____	<input type="checkbox"/> Brain Damage
Name of facility to which patient was transferred: _____	<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.

Cynthia Taylor RN 2202132
Tamee Catalanotto, MA
BRANDI Ransom RN 9188020
Dr Gerald Niedzwiecki - surgeon ME 70649

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)**

Pt Developed groin hematoma after endovascular intervention which used heparin. The percutaneous closure device failed and due to larger body habitus it was difficult to maintain firm vessel pressure with manual compression.

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

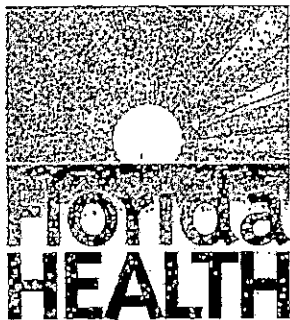
Close monitoring of patients during and after manual compression to potentially minimize size of hematoma.

V.[Signature]
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

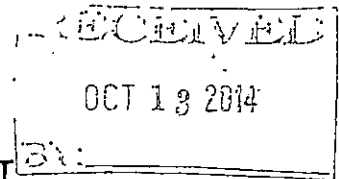
LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED



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 C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office The Vascular Group of Naples 2450 Goodlette Rd N
City Naples Zip Code 34103 County Collier Street Address (239) 643-8794 Suite 202
Telephone NE 98609
Name of Physician or Licensee Reporting Dr. Santiago Chahman License Number & office registration number, if applicable
Patient's address for Physician or Licensee Reporting Same as above

Patient Identification Number

Diagnosis

Age 57 Gender Female ☐ Medicaid ☒ Medicare
Date of Office Visit 10/1/14
Purpose of Office Visit Arterial & Bilateral Iliac Intervention
ICD-9 Code for description of incident 444.22
Level of Surgery (II) or (III) II

III. INCIDENT INFORMATION

Incident Date and Time 10/1/14 @ 12:15 pm

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 N/A

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

57 y/o Female with metastatic Lung cancer
was having Bilateral Iliac intervention with
angioplasty & stenting, massive thrombus
formed on the common Fem Artery
at the sheath level despite Heparin
administration IV. Pt remained stable,
ArOX3, & vital signs stable throughout.
(See attached Op Note)

B) ICD-9-CM Codes

440.22

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)

444.22

Resulting injury (ICD-9 Codes 800-999.9)

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

(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient. <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure. <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital. Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	<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. Santiago Chahwan ME 98409
 Heidi Marlow RN 9311575
 Rhonda Cage RN 83518
 Jordan Martin CRT 74379

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

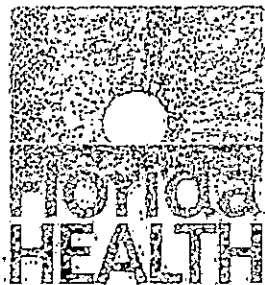
IV. ANALYSIS AND CORRECTIVE ACTION

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

Hypertension state from Hts Lung Cancer, developed Thrombus at left CFA sheet despite Heparin IV, with Acute limb Ischemia left.

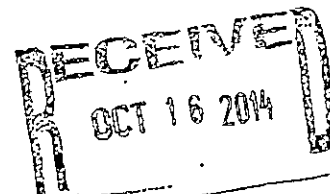
B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

He was taken emergently to NCH ST for left leg Embolectomy.



STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT



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

I. OFFICE INFORMATION

Name of office: Vein and Vascular center of South Florida

City: Hollywood

Zip Code: 33021

County: Broward

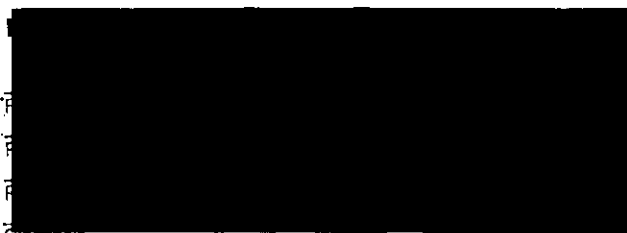
Name of Physician or Licensee Reporting: Melissa Miller

Patient's address for Physician or Licensee Reporting: 19880 NW 64th Court Road

Street Address: 4700 Sheridan Street

Telephone: 954.381.7300

License Number & office registration number, if applicable: OSR 953



Diagnosis

Age: 76 Gender: Female Medicaid Medicare ☐
Date of Office Visit: 10/01/14
Purpose of Office Visit: angiogram
ICD-9 Code for description of Incident: 40.22
Level of Surgery (II) or (III): II

III. INCIDENT INFORMATION

Incident Date and Time: 10/01/14

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)

See attached - Melissa Miller

11/01/2014

During angiogram with intervention to RLE, patient was stable, procedure started at 11:00am, ended at 12:00pm. Right groin 6 French Sheath was pulled at 12:13pm by Melinda Pyke RTRVC, during compression, patient's blood pressure at 12:30 was 81/50. Patient placed in Trendelenburg, second IV started, and fluid bolus given. Patient denied chest pain, back pain or shortness of breath. Pt on $\text{A}^{\text{N}}\text{O}_2$ 3, skin warm and dry. 12:35 pm: compression done being applied to right groin, blood pressure = 94/60; noted flexion to patient's right hip and knee. 12:40 pm: patient's blood pressure = 121/63, no complaints, no neurological evident. 12:50pm: patient transferred to recovery room, vital signs stable, blood pressure = 123/65, patient on $\text{A}^{\text{N}}\text{O}_2$ 3, lying flat, denies any complaint. At 1:30, patient's SBP slightly dropped 95/55, pt on $\text{A}^{\text{N}}\text{O}_2$ 3, denied any back or abdominal pain. Patient, however, persistently kept flexing her right hip and knee, despite multiple requests and attempts at maintaining her right straight. At 1:55, SBP down to 80/49, and another NS IVF bolus and Trendelenburg, patient responded and SBP went up to 111/64. Dr. Fonseca was present at bedside. Patient was comfortable, denied any back pain, her husband was at the bedside. 14 Fr Foley catheter was also inserted at this time, as patient was unable to urinate, return of 400cc amber-colored urine. At 1:512, there was another drop in SBP = 80/49, Dr. Fonseca made aware, another IVF bolus given, and both large bore IVs were running wide open. 1:530 SBP = 100/49, however patient became slightly agitated and wanted to sit up. Decision to call EMT services for further treatment. EMT arrival at 1:546. Dr. Fonseca present and communicated with EMT captain. The patient's last SBP by EMT services was 140/70, and patient denied any complaints. 1:605: patient was transferred to Memorial Pembroke hospital. Melissell PRN

B) ICD-9-CM Codes

440.22
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 of the patient to a 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
Memorial Perinatal	<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. Forbica FL license: ME104324, Christine Madonna RN1444692
Melissa Villar RN19370260, Melinda Pyle CRT60907
Danielle C. RN93861166

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

IV. ANALYSIS AND CORRECTIVE ACTION

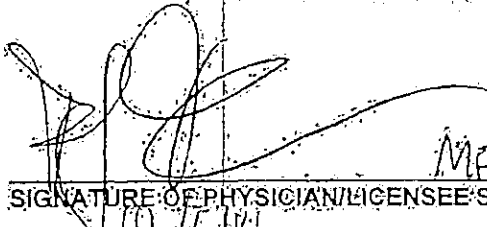
A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Retropneumothorax, hemothorax; corrective action: resuscitation, IV fluids, EMS called and patient transferred to Memorial Perinatal hospital

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

2 Gray tube, IV's, Fluid Resuscitation, Trendelenburg positioning, Foley

V:


SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

ME 104324

10/1/14
DATE REPORT COMPLETED

17:00
TIME REPORT COMPLETED



Consumer Services

OCT 22 2014

FLORIDA
Governor

55

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

Vascular & Interventional Division
Name of office

1881 W Kennedy Blvd.
Street Address

Tampa 33606 Hillsborough
City Zip Code County

813 513 3030
Telephone

Obinna Nwobi
Name of Physician or Licensee Reporting

ME 106633 OSR # 979
License Number & office registration number, if applicable

1881 W Kennedy Blvd. Tampa FL 33606
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Name

Gender

☐ Medicaid ☒ Medicare

Patient's Address
VIP Acct # 10982

Date of Office Visit
10/02/2014

Patient Identification Number
440.23

Purpose of Office Visit
Tortogram & BLE runoff, possible inter
444.22

Diagnosis

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10/02/2014 1920 Approx
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)

Post Op Assessment by Intra Op RN and Surgeon presented to absent right foot DP pulse by Doppler. Pre Op Assessment by Sandy RN (Pre Op RN) pt to dopplerable DP pulses bilaterally, pt also to some mild discoloration of right foot. No C/O pain @ R foot. pt to sensation to R foot. R foot cool touch. pt immediately direct admitted to Tampa Community Hospital (formerly Town & County). via non-emergency EMS services.

B) ICD-9-CM Codes

37227, 37229, 37184
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

444.22
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

emerg 830
459.87
Resulting injury (ICD-9 Codes 800-999.9)
459.9
Peripheral Ischemia of Right Foot

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"/> 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:	<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.

Surgeon: Channa Nwobi ME106633, IntraOp RN: Patrick Scherer RN2907832
Peri Zaba CRT82506 Rad Tech, Shann Clarke Med Assistant
Vendor Reps: Mike Bui 719-314-9052 Spectranetics, Lindsey Kirksey
Please locate NP OR staff @ 813-513-3033 (VP Tampa office) Cordis cell #
Reps cell #s are provided. 813-892-5301

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

Sandy Norton RN9379678 (VIP Tampa office 813-513-3030)
as well as vendor reps listed above. Sandy Clinical Nurse Manager
@ Tampa VP office.

IV. ANALYSIS AND CORRECTIVE ACTION

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

Embolism from heavily calcified vessels

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

Transferred to higher level of care for administration of TPA
opt and close observation.

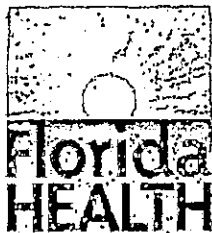
V.

ME106633
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

10/17/2014
DATE REPORT COMPLETED

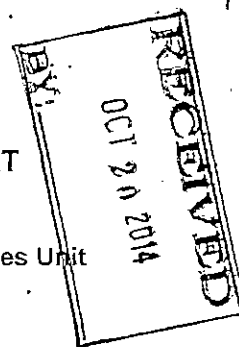
1300
TIME REPORT COMPLETED



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 C75
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

Name of office OB/GYN Specialists of the Palm Beaches Surgery Center Street Address 1447 Medical Park Blvd, Suite 300
City Wellington Zip Code 33414 County Palm Beach Telephone 561-792-4778
Name of Physician or Licensee Reporting Joanne M. Lutz, RN License Number & office registration number, if applicable RN 9168670 OSR # 825
Patient's address for Physician or Licensee Reporting N/A

II. PATIENT INFORMATION

Age 43 Gender Female ☐ Medicaid ☐ Medicare
Date of Office Visit October 2, 2014
Purpose of Office Visit Removal of Bartholin Gland
ICD-9 Code for description of incident 616.2
Level of Surgery (II) or (III) III

III. INCIDENT INFORMATION

Incident Date and Time October 2, 2014 at 0842

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

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)

The patient was seen by Dr. Reilly in early September for left Bartholin gland and was scheduled for an I&D of an abscess. On the day of surgery, September 4, 2014, the abscess had resolved and Dr. Reilly referred the patient to Dr. Tung the next day for excision of the gland. On September 5, 2014 the patient informed Dr. Tung that she has had recurrent problems with both Bartholin glands with multiple I&D procedures and wanted definitive treatment and gland removed. There was no exam completed at the visit and the patient was sent to her primary for pre-operative clearance. On the day of the incident the patient was seen in the pre-operative area.

B) ICD-9-CM Codes

<p>616.2</p> <p>Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)</p>	<p>N/A</p> <p>Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)</p>	<p>N/A</p> <p>Resulting injury (ICD-9 Codes 800-999.9)</p>
--	--	--

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

D) Outcome of Incident (Please check)

<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 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>N/A</u> Name of facility to which patient was transferred: <u>N/A</u>	<input checked="" 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. Chia-Ling Tung ME845589-Surgeon, Dr. Loren Korenga ME95209-Anesthesiologist, Joanne M. Lutz RN, RN9168670 Admission, pre & post-operative recovery, Kelly Thompson Cert# 148656 - Surgical Technician, Lisette Rivera MA - Circulator.

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

N/A

IV. ANALYSIS AND CORRECTIVE ACTION

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

The Analysis concluded that the consent and time out did not follow the facilities procedure. The site of the surgery was not designated on the consent nor during either time out processes.

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

Please see attached:

V.

Joanne M. Lutz
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

RN 9168670
LICENSE NUMBER

October 15, 2014
DATE REPORT COMPLETED

1600
TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor

100
RECEIVED

**PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT**

JUN 17 2014

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

**COMPLAINT
ADMINISTRATION UNIT**

I. OFFICE INFORMATION

COSMETIC SURGICAL GROUP.

Name of office

MIAMI, FL 33175 DADE

City

Zip Code

County

MICARDO P. MESSAS, M.D.

Name of Physician or Licensee Reporting

13431 SW 38 ST MIAMI

Locating information for Physician or Licensee Reporting

13055 SW 42 ST.

Street Address

305-2288380

Telephone

ME-67165

License Number

II. PATIENT INFORMATION

[Redacted Patient Information]

Patient Identification Number

102 EAST AUGMENTATION

Diagnosis

34 F

Age

5.2.14

Gender

☐

Medicaid

☐

Medicare

Date of Office Visit

EVALUATION

Purpose of Office Visit

W/O

ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

NOT AVAILABLE (± 5.23.14 1000H)

Incident Date and Time

Location of Incident

☐ Operating Rm

☒ Other HOME

☐ Recovery 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)

RECEIVED
OCT 08 2014
BY:

Patient D/C after surgical procedure, stable, normal
vitals and without signs of bleeding. Relative
call around 12:00 9:50 PM because nausea and
vomiting, at that time no other complaints
reported. Later at night ± 12:30 patient
call from a local hospital. The answering
service never call the off. or the list
of phone numbers. The patient was admitted
and D/C 23H later because an new tumor
of the breast. Patient was unable
to be contacted after this incident.

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)

Breast Augmentation / Post. Hematoma

NONE

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

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Surgical procedure performed on the wrong patient
- ☐ A procedure to remove unplanned foreign objects remaining from surgical procedure.
- ☐ Any condition that required the transfer of the patient to a licensed hospital

N/A

- ☐ 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

N/A

- ☐ Death
- ☐ Brain Damage
- ☐ Spinal Damage
- ☐ Permanent disfigurement not to include the incision scar
- ☐ Fracture or dislocation of bones or joints
- ☐ Limitation of neurological, physical, or sensory function;
- ☐ Any condition that required the transfer of the patient

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

RICARDO PUEGAS ME 67165
FRANK ALVAREZ ME 46348
JOSE GARCIA RN 9348735

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

ALEX LOPEZ
SANDRA GOTAL OFF. 13055 SW 42 ST
MIAMI, FL.

IV. ANALYSIS AND CORRECTIVE ACTION

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

POSS. EMBESIS INJURED BLEEDING OVER
RECENT SURGICAL SITE

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

ANALYSIS SERVICES WAS DIC. AND
LETTERS SENT TO PATIENT / CAREGIVERS

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

Heart and Vascular Center
Dr. Manuel A. Gonzalez
815 NW 87 Ave. Box 130
Miami, FL 33128



7014 0510 0000 6442 2909



UNITED STATES
POSTAL SERVICE



1000

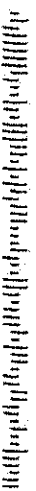
32398

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Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, FL 32399-3275

32398327598

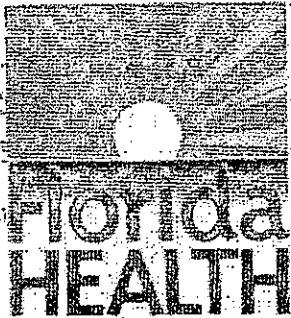
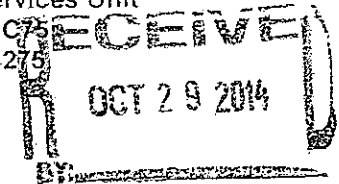


173

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 C75
Tallahassee, Florida 32399-3275



I. OFFICE INFORMATION

Vascular Surgery Associates
Name of office

Tallahassee, FL 32308 Leon
City Zip Code County

Dr. Robert Brumberg
Name of Physician or Licensee Reporting

3964 Camino Real Tallahassee FL 32304
Patient's address for Physician or Licensee Reporting

2631 Centennial Blvd
Street Address

850-877-8530
Telephone

OS9800 OSR925
License Number & office registration number, if applicable

67 57 male ☐ Medicaid ☒ Medicare
Age Gender
10-10-14
Date of Office Visit
Abdominal aortogram with femoral run off
Purpose of Office Visit
E878.8 444.22
ICD-9 Code for description of incident
Level II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10-10-14 10454
Incident Date and Time

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other angiography suite

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)

1045 Patient in recovery (following aortogram), became hypotensive, bradycardic, diaphoretic and nauseated.
1050 Dr. Brumberg notified, IV fluid bolus started. 1055 Dr Brumberg at bedside, patient noted to have significant scrotal swelling
1100 Bedside dulpex showed large scrotal hematoma with compromised arterial flow to testes. Vitals improved.
1115 Order given by Dr. Brumberg to transfer patient to TMH. Urology consulted/notified by Dr. Brumberg, verbal report given.
1135 Patients family notified of need for transfer, EMS contacted. 1150 Patient transferred to TMH via EMS, VSS. Belongings sent with family

B) ICD-9-CM Codes

N/A	E878.8	998.12
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"/> 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 hospital.	<input type="checkbox"/> Brain Damage
Outcome of transfer – e.g., death, brain damage, observation only <u>further evaluation</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred:	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
<u>Tallahassee Memorial Hospital</u>	<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.

Jason Mye RT (R) surgical scrub/rad tech, CRT64941

Julie Angelier, RN staff nurse RN 9305209

Robert Brumberg DO OSA9800

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

Cassie Davis ARNP-C, 9178836 LHRM 5504917

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

AAAC

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 C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Ambulatory Endoscopy Center of Central Florida
Name of office

Longwood, FL 32750 Seminole
City Zip Code County

O. Andrew Giles M.D.
Name of Physician or Licensee Reporting

515 West State Rd. 434, Suite 105 Longwood, FL
Patient's address for Physician or Licensee Reporting 32750

515 West State Rd. 434, Suite 105
Street Address

407-260-6000, Ext. 314
Telephone

ME 46924 Registration #
License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Identification Number

Diagnosis ABDOMINAL PAIN

53 Female ☐ Medicaid ☐ Medicare
Age Gender

10/13/2014
Date of Office Visit

GERD, Diarrhea
Purpose of Office Visit

Abdominal pain 789.07
ICD-9 Code for description of Incident

III
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10/13/14
Incident Date and Time

Location of Incident:
☒ Operating Room ☐ Recovery Room

☒ Other Pt. D&A from unit in good condition
and returned with abdominal pain.

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

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

Pt. had routine, uneventful EGD &
colonoscopy and was discharged from
the endoscopy unit in stable condition without
any abdominal pain. While in car going home
developed severe & vomiting and at home experienced
abdominal pain. Pt advised to return to unit &

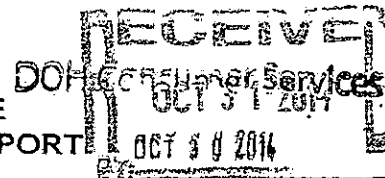


DOH Consumer Services

OCT 30 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 C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office

SIR
Sarasota FL 34232
City Zip Code County

Name of Physician or Licensee Reporting

Dr. Nair
1501 44082
Patient's address for Physician or Licensee Reporting

Street Address

Telephone

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Identification Number

Diagnosis

Age

Gender

☐ Medicaid ☐ Medicare

Date of Office Visit

Purpose of Office Visit

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Incident Date and Time

Location of Incident:

☐ Operating Room
☐ Other

☒ Recovery Room
PAU

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 TO PACU post procedure stable. 3 Hours post procedure pt. developed large hematoma to right groin and scrotum and penis. Manual pressure held to right groin. BP unstable low. Anesthesia notified BP treated. All air notified and present. PT taken to OR. Procedure performed by Dr. Nair to stop and stabilize bleeding. Hemostasis achieved. PT returned to PACU. PT recovered and transferred and admitted for observation at SMH.

DH-MOA1030-12/06 p. Dr. Nair. PT. Stable at time of Discharge.
Page 1 of 2

B) ICD-9-CM Codes

PVD

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"/> 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: SMH	<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.
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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.

Laurie Weathers - RN
 Mike Johnson CRNA - Anest.
 Wendy Saunders - RN
 Joe Swan - Tech
 Dr. Quetschaw - Tech

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)

Cough & Valsalva resulting in disruption & bleeding of puncture site; Immediate staff placed to stop bleeding.

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

staff placed & hospital admission for observation.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED



STATE OF FLORIDA
Charlie Crist, Governor

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

Coastal Gastroenterology
Name of office

Jacksonville 322 USA
City Zip Code County

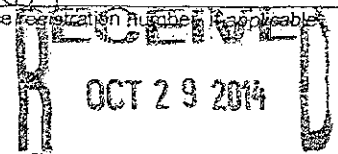
Xiaoqi Li
Name of Physician or Licensee Reporting

68116 Southpoint Pkwy #102
Patient's address for Physician or Licensee Reporting

68116 Southpoint Pkwy #102
Street Address

904-652-2090
Telephone

ME 92069
License Number & office registration number (if applicable)



II. PATIENT INFORMATION

[Redacted Patient Address]

040441 (MED)
Patient Identification Number

V16.51 screening
Diagnosis V16.0 Fam. Ad. colon ca

[Redacted Patient Information]
Age 10-15-14 Gender
Date of Office Visit

colonoscopy
Purpose of Office Visit

ICD-9 Code for description of incident
Level 1 (2)
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10/15/14
Incident Date and Time

Location of Incident:
☐ Operating Room ☐ Recovery Room
☒ Other Endoscopy suite

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 developed bradycardia which quickly progressed to asystole (~10s) during mgt-colonoscopy. Procedure was quickly aborted, pt placed flat and CP was initiated, 1mg atropine given. ACLS initiated and EMS was summoned for transfer to hospital. (See attached)

10/15/14 1101

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)

<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>St Vincent ER</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.
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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.

Matthew Morgan - anesthesiologist ME 103395, X-ray
Li - anesthesiologist ME 92069, Diana - surgical tech
Tina Harris RN 1804322

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)

Bodyguard then asystole

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

ACLS protocols reviewed with all members

V. W. J. and 10/14/14 ME 103395
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
10/14/14 11:01
 DATE REPORT COMPLETED TIME REPORT COMPLETED



COASTAL

GASTROENTEROLOGY AND HEPATOLOGY

10/14/14 1220 Anesthesia Summary

Pt developed bradycardia which rapidly progressed to asystole about midway thru colonoscopy portion of procedure. CP were initiated and 1mg atropine was given. IV upr. pulse returned (120-130s). Pt was also ventilated with positive pressure and bag mask during this time, SpO2 returned @ 92% when pulse returned but NIBP failed to obtain reading; pulse was weak and thready. 1mg epi was also delivered. BP returned in 200s/100s, ST in the 120s-130s & good pulse and SpO2 remained in 80s-90s & bag mask with occasional drops into 70s. At this point EMS was called for during this time for transport to hospital and I tried to intubate the pt twice with MAC 3 initially and MAC 2 but was unable to visualize cords. A combitube airway was inserted via EMS when they arrived but SpO2 dropped into 60s and I felt like ventilations were inadequate. At this point, I did pt on 3rd time with A-MAC 3 and successfully intubated the pt. SpO2 came up to 98%, pt was in SR but pulses became weak again, 0.5mg epi was given with return of pulse and pt was transported to the ER by EMS services. Rpt given to ER doc via telephone while pt was in transport.

ICLS not initiated

NIBP not achieving

M Morgan



COASTAL

GASTROENTEROLOGY AND HEPATOLOGY

6816 SOUTHPOINT PARKWAY, SUITE 102
JACKSONVILLE, FL 32216

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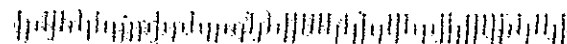
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Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, FL 32399-3225

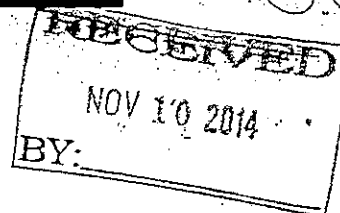
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STATE OF FLORIDA
Rick Scott, Governor



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

Name of office Sarasota Interventional Radiology

Sarasota, FL

City Zip Code County

C. Schiano MD

Name of Physician or Licensee Reporting

Patient's address for Physician or Licensee Reporting

1600 N. Pattman

Street Address

941-378-3231

Telephone

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Diagnosis ESRD

III. INCIDENT INFORMATION

10-24-2014 1430

Incident Date and Time

Age 10 Gender Male Medical Medicare

Date of Office Visit

Purpose of Office Visit Declof AV graft

ICD-9 Code for description of Incident

Level of Surgery (I) or (II)

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)

Patient was having declof of AV graft done. About 25 min after procedure started, he began having significant arrhythmias - bigeminy! VT. P asked if cause to procedure? was informed that a piece of the dilating balloon had broken off. I treated the arrhythmia with no change. A&LS equipment brought into room. We decided expeditious transport to hospital necessary. All called transfer of care done. C. Schiano MD.

The piece of balloon detached separated during the procedure. The detailed description is mentioned in my procedure report.

Hasanul B. Begum
MD

B) ICD-9-CM Codes

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

the separated portion of balloon catheter migrated to Rt pulmonary artery may be the cause of arrhythmia
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Code)

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)

Cook 4cm x 8mm 8mm x 4cm Cook balloon catheter

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.	<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.
---	---

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

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. Schumacher MD anesthesiologist
Dr. Prager MD interventional radiologist
Kristen Wilson CT Technologist
Debra Price RN - Danny Fajiani CT

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)

The broken portion of 8mm x 4mm balloon catheter is migrated into the Rt pulmonary artery may be the cause of ectopic beat

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

Due to persistent irregular heart beat the patient was immediately transferred to Sarasota Memorial Hospital for further management.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

LICENSE NUMBER

DATE REPORT COMPLETED

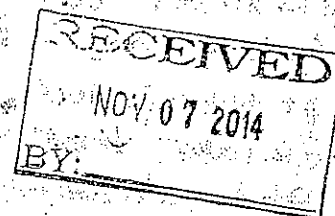
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ME 115578

151



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 C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office Florida Institute for Reproductive medicine 836 Prudential Dr. Suite 902
City Jacksonville FL Zip Code 32207 County Duval Street Address
Telephone 904-399-5620
Name of Physician or Licensee Reporting Gindy Brubaker RN 2842762 OSR # 157
Cecilia Duffy RN 1563772 License Number & office registration number, if applicable
Patient's address for Physician or Licensee Reporting:

II. PATIENT INFORMATION

Age 35 Gender F Medicaid N/A Medicare N/A
Date of Office Visit 10/26/14
Purpose of Office Visit Egg retrieval
ICD-9 Code for description of Incident 628.9
Level of Surgery (II) or (III) II
Patient Identification Number
Diagnosis Infertility

III. INCIDENT INFORMATION

Incident Date and Time 10/26/14 09:17

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)

Nan Harris RN recovering pt after transvaginal oocyte retrieval. 20 minutes into recovery time pt clo worsening pain & nausea. Given Zofran 8mg OOT given. Gindy Brubaker RN in RR to assist pt assessment. Nan went to retrieve Dr. Duffy mo to assess pt. Gindy recovering pt. Pt sat up 1/4 way & clo need to vomit, gave emesis basin, spit out Zofran & approx 1cm sputum - Pt slumped over & unresponsive. Repositioned pt to back & head down. Called for help immediately to RR. obtained crash cart. Carmen called qill. Dr Duffy took over care of pt. nurse bb