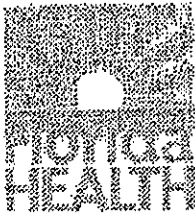


23



No

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

Shore Coast Cancer Center

Name of office

Titusville

32790

BREVARD

City

Zip Code

County

Dr. Juan Castro M.D.

Name of Physician or Licensee Reporting

490 N. Washington Ave. Titusville FL 32790

Patient's address for Physician or Licensee Reporting

490 N. Washington Ave. Titusville, FL 32790

Street Address

321-2108-4200

Telephone

501-2309134

License Number & office registration number, if applicable

II. PATIENT INFORMATION



Patient's Address

Patient Identification Number

Diagnosis

m myeloma



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

April 26, 2015 / 1145

Incident Date and Time

Location of Incident:

☐ Operating Room

☐ Recovery Room

☒ Other, Induction

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 walked into clinic today not feeling well. Pt c/o shortness of breath and nausea. HE Awoke re waken by MA a notable HE at 200. Pt was brought to infusion room to be evaluated by RN After looking at labs. RN contacted Dr. Castro due to patient be symptomatic using external neck muscle. Dr. Castro then decided for EMS to be called. EMS was called and pt was transported to PMU. PT received VS one 1 HR 100, BP 117/88, RR 24

DH-MQA1030-12/06
Page 1 of 2

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

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 0073059
LICENSE NUMBER

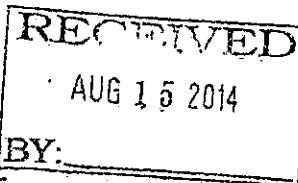
April 26, 2015
DATE REPORT COMPLETED

1245
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

Vascular Access Center of Jacksonville
Name of office

Jacksonville 32216 Duval
City Zip Code County

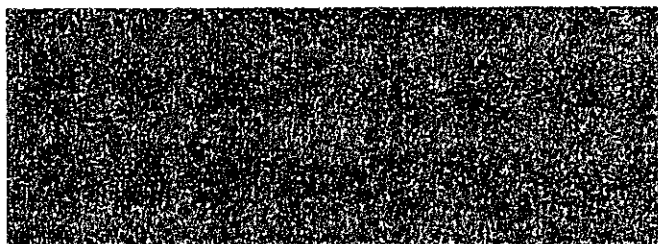
Dr. Ernie Moore
Name of Physician or Licensee Reporting

Patient's address for Physician or Licensee Reporting

1820 Southpark Parkway Suite 1
Street Address

904 296 4106
Telephone

ME 101863
License Number & office registration number, if applicable



80 Female ☐ Medicaid ☒ Medicare
Age Gender

8/4/14
Date of Office Visit

Right upper arm fistulogram
Purpose of Office Visit

ICD-9 Code for description of incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

8/4/15 1303
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 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

45ML non-ionic contrast was used. Fentanyl 50 mcg IV, Versed 1 mg IV, Lidocaine 1 ml SQ, Narcan 0.4 mg IV, Romazicon 0.5 mg IV.

Medications:

Description of Incident (type here): At the end of the procedure(1302) the patient's blood pressure started to decrease and the patient was difficult to arouse, vitals were bp=81/39, rr=14, hr=55, spo2=99 on O2 via nc at 2 l/min. Vital signs were repeated at 1303, results were bp=62/42, rr=14, hr=55, spo2=96 on O2 via nc at 2 l/min. Dr. Moore gave a verbal order for the patient to have Narcan 0.4 mg and Romazicon 0.5 mg IV. Patient was placed on a oxygen simple mask at 15 l/min at 1305 per Dr. Moore's verbal order. Patient received narcan 0.4 mg IV at 1307 and received Romazicon 0.5 mg IV per Dr. Moore's o orders. Pt became more responsive and stated that she was feeling better. Once we attempted to get the patient off of the procedure table she started to lean backwards and said that she did not feel good. We proceeded to move the patient from the procedure table with the slide board onto a stretcher. Patient was moved to the recovery room on the stretcher in the supine position. Initial blood pressure was 64/44 at 1330, repeat blood pressure at 1331 was 65/43. Dr. Moore was informed of the patient's repeated low blood pressures, Dr. Moore gave orders to have the patient sent to St Vincent's Southside Emergency Dept for further evaluation and for an iv and fluids to be started before being transferred. The patient's daughter was informed her mother's status and upcoming transfer to SVMC Southside ER for further evaluation. Jax Fire Rescue was called at 1341. Jax Fire Rescue arrived at 1348. Verbal telephone report given to RN-Sara of SVMC-Southside ER at 1350. Patient left the facility via Jax Fire Rescue at 1356, patient was alert and oriented x 3, and following commands upon transfer from the facility.

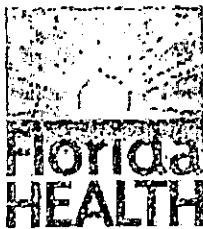
Daughter [REDACTED] was present and said that it was fine to contact her, contact information is home: [REDACTED]

Verbal telephone report called to RN-Susan of DCI Layilla Dialysis Center about the patient becoming hypotensive and being transferred to St Vincent's Medical Center Southside for further evaluation.

A. Huey MD
Center
Manager



Vascular Access Centers is proud to have earned the Joint Commission Seal of Approval.
The Joint Commission Seal of Approval validates Vascular Access Centers' care standards
and commitment to enhanced patient care.
Awaiting Joint Commission recertification



STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

NOV 06 2015

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

I. OFFICE INFORMATION

American Access Care
Name of office
Plantation 33313 Broward
City Zip Code County
Kristen Swanson
Name of Physician or Licensee Reporting

6766 W. Sunrise Blvd Suite 100
Street Address
954-583-8472
Telephone

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[REDACTED]
Patient Name
[REDACTED]
Patient's Address
MR 3601056
Patient Identification Number
ESRD N18.6, Thrombosis T82.868
Diagnosis

[REDACTED] [REDACTED]
Age Gender
10/27/15
Date of Office Visit
Thrombectomy
Purpose of Office Visit
01-99.9
ICD-9 Code for description of incident
II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

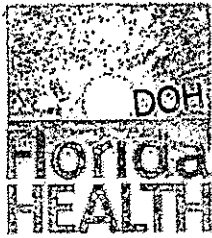
10/27/2015 9:50 Am
Incident Date and Time

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

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

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

SEE ATTACHED



DOH Consumer Services

NOV 03 2015

STATE OF FLORIDA
Rick Scott, Governor

na151
201528578

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

The Cardiac & Vascular Institute

Name of office

Gainesville 32605 Alachua
City Zip Code County

Arthur Lee, MD

Name of Physician or Licensee Reporting

Same

Patient's address for Physician or Licensee Reporting

1151 NW 64 Terr

Street Address

352/375-1212

Telephone

ME 90119 / OSR 805

License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted Patient Name]

[Redacted Patient Address]

158140

Patient Identification Number

Intermittent claudication / Peripheral vascular disease

Diagnosis

[Redacted Patient Photo]

Age

10/20/15

Gender

M

☐ Medicaid ☒ Medicare

Date of Office Visit

Planned atherectomy of peripheral artery

Purpose of Office Visit

I 97.1018

ICD-9 Code for description of incident

II

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10/20/15

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 N/A

Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Pt underwent successful directional atherectomy and angioplasty of right distal SFA. A mnyx closure device was successfully deployed at the end of the case. Pt recovery was normal initially, then developed hematoma and orthostatic hypotension. Hematoma resolved, but ortho hypotension did not. Pt was transferred to hospital via EMS for further evaluation

B) ICD-9-CM Codes

I 70.212 + I 70.213
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

I 97.618
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

I 97.618
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)

Covidreathair One Direction Atherectomy; Cook Balloon; Mynx Closure

D) Outcome of Incident (Please check)

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

Arthur Lee - cardiovascular interventionist; ME 90119
Amber Stevens, RN - Sedation; RN 9345032 / Jacqueline Pfalzgraf, RN - Holding; RN 9232782
Liz Padgett, RCIS; 00088926 (scrub) - Carter Welch, RCIS - monitor; 00079231
Janey Spencer, RN - Holding; Lynne Mercadante RN - holding; RN; 990402

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)

Retroperitoneal bleed secondary to gaining access (known risk). The ultrasound that is routinely used for access guidance, parked during the procedure.

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

ultrasound unit was serviced. Will continue to use for access guidance.

V.

Signature
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 90119
LICENSE NUMBER

10/30/18 @ 1226
DATE REPORT COMPLETED

TIME REPORT COMPLETED

2015 28424

STATE OF FLORIDA
Rick Scott, GovernorPHYSICIAN 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

Sarasota Interventional Radiology
Name of office

600 N.W. Cattlemen Rd
Street Address

941-378-3231
Telephone

Sarasota 34232 FL
City Zip Code County

Dr. C. Grubbs
Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted Patient Name]

[Redacted Patient Address]

[Redacted Patient Identification Number]

[Redacted Patient Identification Number]

Diagnosis

[Redacted Patient Age] M ☐ Medicaid ☒ Medicare
Age Gender

10-22-15
Date of Office Visit
Box Lung Mass / Pneumothorax
Purpose of Office Visit

ICD-9 Code for description of Incident

II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10-22-15 1600
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 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)

Pt. in for a Lung Biopsy on 10-21-15. Pt. developed
a pneumothorax after procedure and a chest tube
was inserted. On 10-22-15 pt returned for a Rescan
Pt on O2-2h cont. - after manual suction, wall suction,
monitoring - there was an unsuccessful inflation of lung.
Per Dr. Grubbs, 911 was called and pt was
sent via ambulance to Lakewood Ranch Hospital.
Vitals remained stable. Continuous O2.

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"/> 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: <u>Lakewood Ranch Medical Center</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.

L. E. Thomas - RN
W. Saunders - RN
C. Howler 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)

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

V.

10/27/15
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 63973
LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

201529323



STATE OF FLORIDA
Charlie Crist, Governor

ha165

DOH Consumer Services

NOV 16 2015

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

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

I. OFFICE INFORMATION

BSS International, Inc
Name of office

Tamarac 33321 Broward
City Zip Code County

Frank Rodriguez, MD
Name of Physician or Licensee Reporting

[REDACTED]
Patient's address for Physician or Licensee Reporting

777 W. University Drive Ste 102
Street Address

904-720-7777
Telephone

ME14909
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[REDACTED]
Patient Name

[REDACTED]
Patient's Address

44105910538
Patient Identification Number

post-operative bleeding
Diagnosis uterine atony

[REDACTED] Fe
Age 11/2/15 Gender 11/3/15
☐ Medicaid ☐ Medicare

Date of Office Visit
2nd trimester therapeutic termination
Purpose of Office Visit OF pregnancy

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11/3/15
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)

11.2.15 Patient seen for evaluation for second trimester abortion and laminarian insertion for a known Trisomy 21 fetus. Review of systems only noted a hypothyroid condition, currently treated with daily Synthroid. Ultrasound findings were consistent with prior studies with no gross abnormal finding noted. Laminaria were inserted with no complications.

11.3.15 D&E performed as per protocol uneventfully. At the end of the procedure the patient was noted to have more than expected uterine bleeding with the patient held in the OR with Medical Management administered. Bleeding improved and patient was transferred to recovery area. Further observation noted more than expected vaginal bleeding despite medical management. Patient and husband were informed the inpatient observation and management would be appropriate.

Page 1 of 2 to recovery area. Further observation noted more than expected vaginal bleeding despite medical management. Patient and husband were informed the inpatient observation and management would be appropriate.

...with stable. Patient was transferred to recovery area.

B) ICD-9-CM Codes

2nd trimester D&E

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)

Post-op bleeding
uterine atony

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>Coral Springs 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.

Robin Hathaway, LPN / PNC636561 - assistant

Angel Carceda M.A. - assistant

Reyanne Rempel M.A. - assistant

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)

uterine atony responding to medical management during the initial 24 hour suspected

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

We are reviewing the issues and preventative/corrective measures with NAEF advisors. We already are in conformity with National Policy and procedures for Second Trimester Abortion

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

ME55556
LICENSE NUMBER

11-9-2015
DATE REPORT COMPLETED

16:52
TIME REPORT COMPLETED

V.

Jnfn
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
11/18/15
DATE REPORT COMPLETED

11:51
TIME REPORT COMPLETED

RN9356622
LICENSE NUMBER



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

Consumer Services

NOV 06 2015

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

I. OFFICE INFORMATION

Riverside Surgery Center
Name of office
Sebastian FL Indian River
City Zip Code County
Lily Voepel
Name of Physician or Licensee Reporting

14410 U.S. 1
Street Address
772-589-8111
Telephone
ME85032
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[REDACTED]
Patient Name
[REDACTED]
Patient's Address
[REDACTED]
Patient Identification Number
Thoracic disc degeneration
Diagnosis

[REDACTED] [REDACTED]
Age Gender Medicaid Medicare
10-21-15
Date of Office Visit
Thoracic 9-10 Epidural
Purpose of Office Visit
M51.34
ICD-9 Code for description of incident
II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

10/21/15
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 came in for Bilat T9-10 injection with Dr Voepel with
no anesthesia - Local only - pt arrived to PACU @ 134K
Very anxious, moving all extremities, waiting in pain, stating his
upper back was in spasms, Dr Voepel checked, after Spasms
pt had numbness + no movement in bilateral arms + legs but
able to feel touch, no touch, no improvement, Dr Voepel spoke with
pt + wife, transferred - Reba Baul

A) Describe circumstances of the incident:

The patient had a left lower extremity angiogram completed on 11/10/2015. Patient brought to recovery room at 1235. At 1315 patient's complaint of left calf pain. RN noticed skin was taught. MD was called to bedside. 1325 Gave the orders to transfer patient to Largo Medical Center as he suspected compartment syndrome. Patient taken by ambulance to LMC at 1359. Throughout incident patient vitals remained stable. Pain medication given to ease discomfort with minor results.

IV. Analysis of the incident

A) Apparent cause of the incident

- a. Wire perforation during the procedure without extravasation seen on fluoroscopy

B) Corrective action

- a. Emphasis on wire location/education will be provided
- b. Pain management and quick assessment of patient's complaint of pain

B) ICD-9-CM Codes

M5134 M5414
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)

M5134
Resulting injury (ICD-9 Codes 800-999.9)

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

(Use additional sheets as necessary for complete response)

None

D) Outcome of Incident (Please check)

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

Outcome of transfer – e.g., death, brain damage, observation only

Name of facility to which patient was transferred:

transferred to Sebastian River Medical Center per EMS (per Dr. Vaegel)
Discharged 11/25/15

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

** if it resulted in:

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

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

<u>Dr. Vaegel MD</u>	<u>ME 85032</u>	<u>Ange Carrasquillo RMA#2640608</u>
<u>Joseline McDonald nurse</u>	<u>1835749</u>	
<u>Rebecca Bonner RN</u>	<u>RN 9255857</u>	
<u>Nancy Connor RN</u>	<u>RN 1557372</u>	

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)

Pt did not take antihypertensives on day of procedure. Facility does not have cancellation policy for local pts. Pt's BP rose after the procedure d/t back spasms

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

Facility policy will be reviewed. Parameters for cancellation of local pts will be established. New policy will be ~~immediately~~ implemented and staff educated

V:

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 85032
LICENSE NUMBER

10-27-15
DATE REPORT COMPLETED

1400
TIME REPORT COMPLETED

2015 29212 119



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

RECEIVED
NOV 13 2015

I. OFFICE INFORMATION

Tampa Bay Vascular Ctr
Name of office

Clearwater 33761 Pinellas
City Zip Code County

Dr. Wesley GABARD
Name of Physician or Licensee Reporting

29296 US Hwy 19 N. Suite 4
Street Address

727-784-8444
Telephone

Office Surgery Registration #694
License Number & office registration number, if applicable

[Redacted]

[Redacted]

Age 10/28/15 Gender Male ☐ Medicaid ☒ Medicare

Date of Office Visit

Purpose of Office Visit Angioplasty

ICD-9 Code for description of incident

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

230087457
Patient Identification Number
Decreased flow in HD access
Diagnosis

III. INCIDENT INFORMATION

10/28/15 10:08 AM
Incident Date and Time

Location of Incident:

☒ Operating Room

☐ Recovery Room

☐ Other

Note: If the incident involved a death, was the medical examiner notified? ☐ Yes ☒ No

Was an autopsy performed? ☐ Yes ☒ No N/A

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

See Attachment

B) ICD-10CM Codes T82.868A

I46.9

T82.898A, T82.858A

R40.1, 92950

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-10 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-10 E-Codes)

Resulting injury (ICD-10 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"/> ** 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>E.R.</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>Mease Countryside 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.

Dr. Wesley GABBARO (ME 105493)

Caleb Burton, RT (CRT76400/ARRT 461990)

Deborah Pounders, RT (CRT484281/ARRT 323791)

Holly Gitting, RN 9362656

ANTHONY RIGGIO, RT (CRT598151/ARRT 361473) & Elizabeth Schuster, RN

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

PERSONNEL LISTED ABOVE AND EMS

IV. ANALYSIS AND CORRECTIVE ACTION

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

See Attachment

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

See Attachment

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 105493

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

VII A Continued

Further inpatient management and observation proceeded. No surgical intervention was necessary with the patient discharged home after 48 hours of inpatient observation.



31

STATE OF FLORIDA
Rick Scott, Governor DOH Consumer Services

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

APR 21 2015

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

Lehigh Acres 33936 Lee

City Zip Code County

Cyrus Anderson, M.D.

Name of Physician or Licensee Rendering

1110 Lee Blvd.

Street Address

239-936-2316

Telephone

ME101126

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Name

Patient's Address 100373323

Patient Identification Number 789.00

Diagnosis

Age

03/24/2015

Gender

☐ Medicaid

☐ Medicare

Date of Office Visit

CT abdomen & pelvis

Purpose of Office Visit

74178

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

03/24/2015 10:30 am

Incident Date and Time

Location of Incident:

☐ Operating Room

☐ Other Hospital Room

☐ 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 completing CT examination the patient experienced anaphylactic reaction to the CT intravenous contrast with coughing, wheezing and respiratory symptoms. The patient received a 1 mg epinephrine and 50 mg Benadryl IM, albuterol three puffs and Solu-medrol 125 mg intravenously. The patient was improving when EMS arrived and transported to the emergency room for further evaluation and stabilization.

██████ was referred to the TBVC for evaluation of █████ fistula. █████ states that the HDU (dialysis center) personnel have been having issues cannulating the fistula more proximal in █████ forearm. The personnel also auscultated a "high-pitched" bruit in the fistula. On exam, patient has a left forearm radial artery to cephalic vein fistula. The body of the fistula had dilated, but the pulsation was quite soft. The fistula did not augment well. On ultrasound, the anastomosis appeared to be quite stenosed. The blood flow was diminished on color Doppler. The body of the fistula had dilated.

The overall case was started at 9:28 AM. A total of 70 mg/ml of Omnipaque contrast was used. A total of 5 mg of Versed and 150mcg of Fentanyl were given during the entire case. A total of 70 mL of 300 mg/ml Omnipaque was injected. A total of 0.5 mg of Flumazenil and 0.4 mg of Naloxone were given. Complications from the procedure were classified type IX and graded 3. The procedure ended at 10:15 AM. The overall case end time was recorded as 10:49 AM.

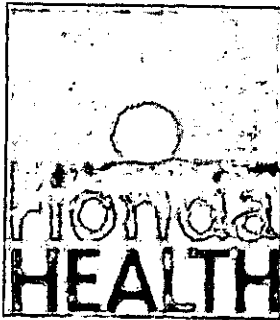
Event: Almost at the conclusion of the procedure, █████ became unresponsive. █████ began to have diminished oxygen saturations. █████ was reversed with 0.5mg of flumazenil and 0.4mg of naloxone given intravenously using the venous sheaths. This was unsuccessful. █████ became pulseless with PEA with a heart rate in the 20s. CPR was started. █████ was given 1mg of epinephrine with good CPR performed. █████ oxygen saturations did not improve, so █████ was intubated by Dr. Wesley Gabbard. █████ oxygen saturations responded. █████ rhythm changed to VTach. █████ still had no pulse. █████ was given 300mg of amiodarone intravenously while CPR was continued. By the time the defibrillator was charged, █████ had changed to sinus tachycardia with a HR of about 120 bpm with a bounding pulse. He was not defibrillated. █████ then, started moving all of █████ extremities and opened █████ eyes. █████ returned to █████ initial HR in the high 50s with a BP of 120s/70s. █████ was transferred to Mease Countryside ED by EMS. Report was given to the ED physician (Dr. Hughes) by Dr. Wesley Gabbard.

Team debriefing of the event took place with the physician and team. Case was reviewed. Procedures that were performed were deemed successful. There were no device failures during the treatment of this patient. Root Cause Analysis completed and submitted to our Director of Quality.

P. Achuster, RN. 11/5/15

STATE OF FLORIDA
Rick Scott, Governor

DEC 15 2015



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 Vascular Access Center of Jacksonville 6820 Southpoint Pkwy Suite 1
City Jacksonville Zip Code 32216 County Duval Telephone 904-296-4106

Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Name [REDACTED] Age 12/4/15 Gender Male ☐ Medicaid ☐ Medicare
Patient's Address 25234 Date of Office Visit 12/4/15
Patient Identification Number ESRD Purpose of Office Visit Right thigh fistulogram/Thrombectomy
Diagnosis ESRD ICD-9 Code for description of incident II
Level of Surgery (II) or (III) II

III. INCIDENT INFORMATION

Incident Date and Time 12/4/15 @ 1340 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 Form.

Description of incident (type here): PROCEDURE: After informed consent was obtained and the patient was prepped in a sterile manner, access was obtained to the right leg loop fistula with a micropuncture sheath. This was upsized to a 6Fr sheath and an angled glide cath was advanced into the central circulation over a stiff angled guidewire. Fistulogram was performed with pull back to the area of thrombus, located at the venous anastomosis. An alternate 6 Fr sheath was placed in the arterial and venous directions. Fogarty thrombectomy of the arterial plug was performed. The clotted AVG was laced with 2mg TPA while inflow was controlled with the fogarty balloon. Balloon angioplasty with an 8mm balloon was performed along the entire AVG into the femoral and iliac veins. Retrograde angiogram demonstrated proximal stenosis in the AVG which was also ballooned with an 8mm balloon. A good thrill was noted clinically and follow-up fistulagram and venogram demonstrated wide patency at the angioplasty sites and into the central venous circulation. The sheaths were removed after placement of 3-0 nylon sutures.

During the procedure after sedation the patient became nonresponsive, hypotensive and had labored breathing. He was immediately given reversal agents x2 but required bag mask to maintain oxygenation for several minutes. Eventually he became more responsive, his breathing improved and his BP recovered. EMS was called and the patient was taken to the ER for further workup and treatment.

PROCEDURE: After informed consent was obtained and the patient was prepped in a sterile manner, access was obtained to the right leg loop fistula with a micropuncture sheath. This was upsized to a 6Fr sheath and an angled glide cath was advanced into the central circulation over a stiff angled guidewire. Fistulogram was performed with pull back to the area of thrombus, located at the venous anastomosis. An alternate 6 Fr sheath was placed in the arterial and venous directions. Fogarty thrombectomy of the arterial plug was performed. The clotted AVG was laced with 2mg TPA while inflow was controlled with the fogarty balloon. Balloon angioplasty with an 8mm balloon was performed along the entire AVG into the femoral and iliac veins. Retrograde angiogram demonstrated proximal stenosis in the AVG which was also ballooned with an 8mm balloon. A good thrill was noted clinically and follow-up fistulagram and venogram demonstrated wide patency at the angioplasty sites and into the central venous circulation. The sheaths were removed after placement of 3-0 nylon sutures.

During the procedure after sedation the patient became nonresponsive, hypotensive and had labored breathing. He was immediately given reversal agents x2 but required bag mask to maintain oxygenation for several minutes. Eventually he became more responsive, his breathing improved and his BP recovered. EMS was called and the patient was taken to the ER for further workup and treatment.

Contrast: 50 ml

Radiation: 65.31 mGy

Fluoro time: 8.2 min

Post op vitals BP 145/72 HR 86 RESP 10 SATURATION 95% ON 100% AMBU

B) ICD-9-CM Codes

585.6

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 <u>At sent home same day</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred: <u>Mayo Clinic</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 Sara Clark - ME 119747

Elizabeth Hamilton RT ARRT 391211/CET 61244

Rima Hernandez RN 9258203

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 did not tolerate sedation & it was felt that due to kidney disease & liver disease it took extra time to get reversal to take effect

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

will use caution when giving moderate sedation to patients with liver & kidney disease as it may take longer to take effect as metabolism is slowed.

DH-MQA1030-12/06



PHYSICIAN OFFICE ADVERSE
INCIDENT REPORT

DOH Consumer Services

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

JAN 21 2015

I. OFFICE INFORMATION

American Access Care of Jacksonville

Name of office

Jacksonville
City

32204
Zip Code

Duval
County

Kok L Chong

Name of Physician or Licensee Reporting

800 Lomax St, Suite 100, Jacksonville, FL 32204

Patient's address for Physician or Licensee Reporting

800 Lomax St, Suite 100

Street Address

904-353-3664

Telephone

ME 105841

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient's Address

800691

Patient Identification Number

ESRD

Diagnosis

Age

Gender

Medicaid Medicare

1/5/2015

Date of Office Visit

Aneurysm Evaluation, ESRD Evaluation & Management

Purpose of Office Visit

585.6, 442.9

ICD-9 Code for description of incident

II

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1/5/2015 10:00AM

Incident Date and Time

Location of Incident:

X 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)

Upon arrival at AAC, the patient's vital signs were: BP=162/98, P=75, R=18, Temp=98.2. The patient exhibited a large pseudo-aneurysm on the left forearm over the AVGraft. While the patient was undergoing a procedure involving angioplasty, the pseudo-aneurysm on the left forearm ruptured, resulting in bleeding which was subsequently controlled with a covered stent graft and the procedure was terminated and hemostasis was achieved. After the procedure, the patient was moved to the post-procedure area without incident and placed in a semi-fowlers position on a bed. The patient's vital signs prior to transport to the hospital were: BP=160/90, P=112, R=16, O2 sats=99% on room air. EMS was called, at Dr Chong's request, and the patient was transported per request to Baptist Medical Center Jacksonville.

B) ICD-9-CM Codes

585.6	459.2, 996.1	442.9
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)

D) Outcome of Incident (Please check)

Death	Surgical procedure performed on the wrong site **
Brain Damage	Wrong surgical procedure performed **
Spinal Damage	X Surgical repair of injuries or damage from a surgical procedure.
Surgical procedure performed on the wrong patient.	** if it resulted in:
A procedure to remove unplanned foreign objects remaining from surgical procedure.	Death
X Any condition that required the transfer of the patient to a hospital.	Brain Damage
Outcome of transfer – e.g., death, brain damage, observation only surgical revision the AV Graft.	Spinal Damage
Name of facility to which patient was transferred: Baptist Hospital (Downtown Jacksonville)	Permanent disfigurement not to include the incision scar
	Fracture or dislocation of bones or joints
	Limitation of neurological, physical, or sensory function.
	Any condition that required the transfer of the patient to a hospital.

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

Kok L Chong, Medical Director, ME 105841

Mark Hamilton, RN, RN 9343176

Jose Rojas, RT, CRT 83201

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)**

Pre-existing pseudo-aneurysm on left forearm.

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

Bleeding was controlled with a covered stent graft, the procedure was terminated, and hemostasis was achieved. Patient was sent to

ED of choice via ambulance, where had a chest catheter placed, and surgical revision of graft.

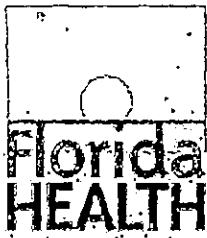
V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

DATE REPORT COMPLETED

TIME REPORT COMPLETED

ME 105841
LICENSE NUMBER



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 Radiology Assoc of Venice&Englewood 512-516 Nokomis Ave S
Street Address
Venice 34285 Sarasota (941) 488-7781
City Zip Code County Telephone
Gary D. Wright, MD ME59822
Name of Physician or Licensee Reporting License Number & office registration number, if applicable
512-516 Nokomis Ave S, Venice, FL 34285
Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[REDACTED]
Patient Name
[REDACTED]
Patient's Address
119165
Patient Identification Number
Evaluate for pre-bypass surg
Diagnosis

[REDACTED] Female
Age Gender ☐ Medicaid ☐ Medicare
01-12-2015
Date of Office Visit
CIA runoff
Purpose of Office Visit
995.29
ICD-9 Code for description of incident
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

01-12-2015 @ 9:35 AM
Incident Date and Time

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

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

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

See attached documentation

B) ICD-9-CM Codes

75635
Surgical, diagnostic, or treatment
procedure being performed at time of
incident (ICD-9 Codes 01-99.9)

995.29
Accident, event, circumstances, or
specific agent that caused the injury,
or event. (ICD-9 E-Codes)

786.05
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 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>Observation</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>Venice Regional Bayfront</u>	<input type="checkbox"/> Fracture or dislocation of bones or joints
<u>Hospital</u>	<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.

Lindsay Neeley, RN RN9242658

Michael McKinnon, RT (R) (N) CNMT (PET) CRT30860

Gary Wright, MD ME59822

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)

Chest & throat tightness with wheezing and SOB post-injection
of IV contrast.

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

Contrast lot # identified and pulled. Patient's chart noted
"Pre-medicate, adverse reaction"

V.

Gary Wright MD
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT
01-15-2015

ME59822

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED
11:50 AM

201529843

1165

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

Choice Health Care DBA Vascular
Interventional Pavilion

St. Petersburg 33709 Pinellas
City Zip Code County

Lindsay Schoen
Name of Physician or Licensee Reporting

5000 Park St N
Street Address

727-827-2993
Telephone

OSR # 1082
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient's Address
10212
Patient Identification Number
PAD
Diagnosis

[Redacted]
Age 11/10/15 Gender [Redacted] Medicaid Medicare
Date of Office Visit
Left lower extremity Angiogram
Purpose of Office Visit
729.72
ICD-9 Code for description of Incident
11
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

11/10/15 1315
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

88.48
Surgical, diagnostic, or treatment
procedure being performed at time of
incident (ICD-9 Codes 01-99.9)

E810
Accident, event, circumstances, or
specific agent that caused the injury
or event. (ICD-9 E-Codes)

729.72
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: <u>Large Medical Center</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.

Obinna Nwadi - ME 106633 - MD
Sandra Norton - RN 9379678 - Recovery RN
Dustin Buchanan - RN 9364537 - Recovery RN
Josh Barnes - ARNP - CRNA
Sajid Ismail - OS 18460 - scrub tech

F) List witnesses, including license numbers if licensed, and locating information if not listed above
Lindsay Schen - RN 9361672

IV. ANALYSIS AND CORRECTIVE ACTION

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

see Attached

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

see Attached

CORAL GABLES COSMETIC CENTER

FOLLOW UP

Name: _____

Date: 8/12/13
14:00

Subjective:

Around 7 hours ago, dismissed case
Dr. Sean Kennen (Neurology) who explained
that for unknown reasons the pt. has cerebral edema
on CT scan. Neurosurgeon was consulted
for monitoring device and the patient

Objective:

is being treated with hypertonic saline.
He said that it is possible to recover
from this especially if young.

Assessment:

Will return to hospital forthwith where
pt. is being treated in the ICU.
Will check toxicology screen and
collar pt closely.

Plan:

Return for Follow-Up: _____

Physician's Signature

Patient's Signature

pt 684

RADIOLOGY ASSOCIATES OF VENICE & ENGLEWOOD

ADVERSE REACTION TO IV CONTRAST

NAME: [REDACTED] RADIOLOGY ASSOCIATES OF VENICE AND ENGLEWOOD

DOB: [REDACTED]

DATE OF EX: 11/16/15 CTAR - CTA ABDOMEN WITH BI. SEX: F

ORDERING: SMITH, BRYAN L MD 01/12/2015 - 9:00 AM (941) 488-7742

EXAM: CTA Runoff CT injected 9:15 AM
150 cc 370 LOT # ADP 4651A

EVENTS OF REACTION

PLEASE LIST: s/p contrast injection, pt. reported chest/throat tightness, redness to face/arms/legs, audible wheezing, SOB, HR 140, BP 110/80, RR 30, SpO2 98%. Pt continued wheezing - per nebulizer proximal inhaler used. All called. ER notified of need for continued observation. Pt reported nausea/heaving. Per Dr. Wright - pt. not to have contrast unless absolutely necessary and must be premedicated due to bronchospasm & bronchial edema.

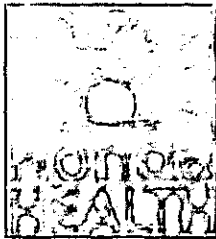
TIME: 9:35 SYMPTOMS: Trouble breathing, swallowing

DRUGS ADMINISTERED: Epinephrine 1:10,000 (0.4mg) IV; Benadryl 50mg IV; 200ml NSS

RADIOLOGIST INVOLVED: Dr. Wright

STAFF INVOLVED: Lindsay Neely, Mike McKinnon, Dr. C. Wright

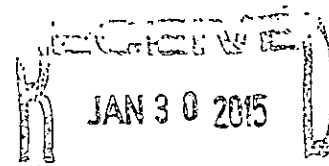
DISMISSAL PROCEDURE: Pt. transported to VRSB ER via EMS, with her condition somewhat improved (HR 98, RR 20, SpO2 98%). (hx CABG - cardiac bypass) 05/05



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

The Cardiac Vascular Institute
Name of office
Gainesville 32605 Alachua
City Zip Code County
Dr. Timothy Wessel
Name of Physician or Licensee Reporting
1151 NW 64 Terr, Suite 32605
Patient's address for Physician or Licensee Reporting

1151 NW 64 Terr
Street Address
352/375-1212
Telephone
ME85153 / OSR #805
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted]
Patient Name
[Redacted]
Patient's Address
12653
Patient Identification Number
CAD (414-01)
Diagnosis

[Redacted] F
Age Gender
Jan 15, 2015
Date of Office Visit
Scheduled diagnostic LHC
Purpose of Office Visit
780.02
ICD-9 Code for description of incident
II
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1/15/15 @ 1300-1555
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 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)

Pt Ehy of CAD, chronic hypertension, carotid artery disease, and possible TIA, presented for LHC 2° to angina and disease progression in previously bypassed area and consideration of renal stenting 2° to renal stenosis. Pt presented pre-procedure BP of 276/117. Pt medicated E10mg Procardia p.o. and 4mg Nitrostat SL @ 1145 per verbal order from Dr. Wessel. At onset of procedure BP 198/132. Please see attached note for additional detail pages 1a and 1b.

B) ICD-9-CM Codes

<u>414.02 and 402</u>	<u>E878</u>	<u>436</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-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)

It was undergoing dx cardiac cath and renal stenting. No specific equipment was associated with event.

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>hospitalized - DIC 1/27/15</u> Name of facility to which patient was transferred: <u>North Florida 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.
--	---

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.

Timothy Wessel, MD - ME 85153 ; cardiologist providing care ; Tiffany Burgett RN - RN 9297499, sedation nurse ; Jamey Spencer, CVT, scrub tech ; Elizabeth Padgett RCLS, monitor ; Carlee Welch, RCLS, circulator ; Cathy Miller, LPN, ANS 16454, Holding Nurse ; Lynne Mercadante, RN - 980402, Holding Nurse

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

Jessica DeLuca, scheduler

IV. ANALYSIS AND CORRECTIVE ACTION

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

Stroke is a rare (1 in 1,000) and unfortunate known complication of cardiac catheterization.

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

Case to be reviewed at upcoming M&M conference at which time any appropriate process changes will be discussed

V. + <u>[Signature]</u>	<u>ME 85153</u>
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
<u>January 27, 2015</u>	<u>1540</u>
DATE REPORT COMPLETED	TIME REPORT COMPLETED

201504524

186



STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

FEB 05 2015

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 32216 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. South

Street Address

904-493-3333

Telephone

N/A

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Name

Patient's Address

MR# 528190

Patient Identification Number

Diagnosis

Age

01/19/2015

Date of Office Visit

Carotid Angiogram

Purpose of Office Visit

998.12

ICD-9 Code for description of incident

(II)

Level of Surgery (II) or (III)

Female

Gender

☒☒

Medicaid Medicare

III. INCIDENT INFORMATION

01-19-2015 @ 11:15PM

Incident Date and Time

Location of Incident:

☐ Operating Room☒ Recovery Room☐ OtherNote: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ NoWas an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Patient had a 4 fr sheath in the left groin D/C'd post procedure. Patient had an unremarkable recovery until patient ambulated to restroom. Upon return to recovery room a large hematoma was noted at the left groin procedural site. Manual compression was applied. Per MD patient to be transferred to Memorial Hospital for observation. Patient left in stable condition.

B) ICD-9-CM Codes

36215

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)

998.12

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>Observation Only</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred: <u>Memorial Hospital</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.

Courtney Fluharty RN (9217469), Marjorie Matheny RN (9395929), Jason Cook (RT9160)

Yazan Khattib MD (ME 85393)

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)

Carotid Angiogram via Left Femoral Approach

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

Patient Transfers are closely monitored and tracked by physicians, staff, and administration

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 85393

LICENSE NUMBER

02-02-2015

2:30 PM

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA1030-12/06

Page 2 of 2



DOH Consumer Services

FEB 03 2015

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

First Coast Cardiovascular Institute

Name of office

Jacksonville, FL 32216 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. South

Street Address

904-493-3333

Telephone

N/A

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient's Address

MR# 566120

Patient Identification Number

Coronary Artery Disease

Diagnosis

Male ☐ Female ☒
Age Gender Medicaid Medicare

01/19/2015

Date of Office Visit
Left Heart Cath

Purpose of Office Visit
998.4

ICD-9 Code for description of incident
(II)

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

01/19/2015 @ 2030

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)

Post procedure during sheath removal, the sheath separated and performing Physician, (Dr. Khatib) was unable to remove the entire sheath. Vascular hemostasis was obtained using a T-R band at the left radial site. Patient's O2 saturation remained unchanged at 94 % on left hand. Patient was transferred in stable condition to Memorial Hospital for surgical extraction of sheath.

B) ICD-9-CM Codes

414.01

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

E871.9

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)

Cook Raabe Sheath (Ref# G29981 Lot # 4880322)

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 checked="" 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
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.

Jason Cook - RRT RT9160, Philip Avevor - CRT 68800, Janie Jenkins - RN 9242170

Yazan Khatib - MD ME85393

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)

Left heart Cath via Left Radial Approach

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

Patient transfers are closely monitored and tracked by physicians, staff, and administration.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 85393

LICENSE NUMBER

01/28/2015

12PM

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA1030-12/06

Page 2 of 2

201505167 173

STATE OF FLORIDA

Consumer Services



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

FEB 02 2015

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

I. OFFICE INFORMATION

The Vascular & Interventional Pavilion 3500 38th Ave N

Name of office Street Address
St Pete FL 33713 Pinellas 727 827 2993

City Zip Code County Telephone
Danna U Nwobi NE 106633 O&R #933

Name of Physician or Licensee Reporting License Number & office registration number, if applicable
3500 38th Ave N, St Pete, FL 33713

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted] Age [Redacted]
[Redacted] Gender [Redacted] Medicaid [Redacted] Medicare [Redacted]
Patient's Address Date
11140
Patient Identification Number Purpose
1110.25
Diagnosis ICD-9 10
Level
of Office Visit
Hortogram
of Office Visit 998.2 (cd9)
Code for description of incident (II)
of Surgery (II) or (III)

III. INCIDENT INFORMATION

01/20/2015 between the hours of 1353-1543
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 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)

See attached sheet.

B) ICD-9-CM Codes

88.42

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

Accidental puncture during procedure, nec 998.2

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

Hypotension

458.9 & 285.9

Resulting injury (ICD-9 Codes 800-999.9)

Anemia

Angiography of femoral & other lower extremity arteries

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

None. N/A

D) Outcome of Incident (Please check)

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

Outcome of transfer -- e.g., death, brain damage, observation only

Name of facility to which patient was transferred:

St. Pete General

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

** if it resulted in:

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

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

Donna Dwobi ME 106633: Surgeon: 727 827 2993

Kelly Goe RN 9246056: Nurse Manager

Ryan Lewis RN 9245678: CRNA

Lindsay Schoen RN 9356622: Recovery RN

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

None

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.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

01/20/2015

DATE REPORT COMPLETED

2:00

TIME REPORT COMPLETED

ME 106633

LICENSE NUMBER

STATE OF FLORIDA PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

III. INCIDENT INFORMATION

A) Describe circumstances of the incident (narrative)

Patient with persistent hypotension despite interventions of Normal Saline boluses and medications of Neosynephrine, Romazicon and Narcan. Patient neurologically intact throughout recovery period. Bilateral groin access sites remains soft and without hematoma. No drainage at bilateral groin access sites. Bilateral Doppler dorsal pedal and posterior tibial pulses remain intact throughout recovery period. Decision then made by MD to send patient to the hospital for further observation and evaluation by a higher level of care and CT scan.

IV. ANALYSIS AND CORRECTIVE ACTION

A). Analysis (apparent cause) of this incident- -----

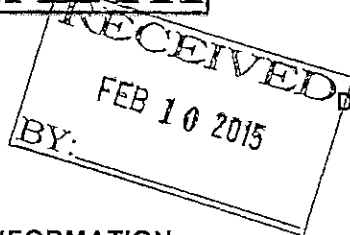
Right groin initially with oozing. Manual pressure held for the first 5 minutes of post-operative recovery. Underlying anemia causing hypotension.

B) Describe corrective or proactive actions taken

Reversal agents, Neosynephrine, Normal Saline boluses. Transferred to higher level of care.

201505175 - 35

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

American Access Care of Orlando

Name of office

Orlando 32806 Orange
City Zip Code County

Warren S. Krackov

Name of Physician or Licensee Reporting

Same

Patient's address for Physician or Licensee Reporting

1405 S. Orange Ave. Orlando FL 32806

Street Address

407-425-5062

Telephone

ME101445 / OSR 749

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Name

Patient's Address

1200448

Patient Identification Number

ESRD

Diagnosis

male

Gender

☐

Medical

☒

Medicare

Age

01/23/2015

Date of Office Visit

Dialysis Access Thrombectomy

Purpose of Office Visit

36147 / 36148

ICD-9 Code for description of Incident

III

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

01/23/2015 @ 9:05 AM

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)

Please see attached

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
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.

Warren S. Krackov, MD ME101445

Jennifer Rodriguez, RN RN 9263170

Victoria Gonzales RT, CRT31261

Nicole Goodman

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

As described in section E

IV. ANALYSIS AND CORRECTIVE ACTION**A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)**

The patient appeared to have an acute cardiopulmonary process that required immediate attention in a hospital; and this was provided without delay

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

EMS was contacted as PT symptoms warranted further evaluation at the hospital.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME101445

LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA1030-12/06

Page 2 of 2



American Access Care

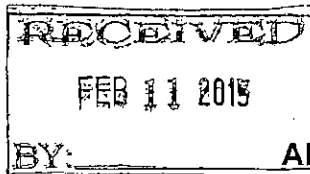
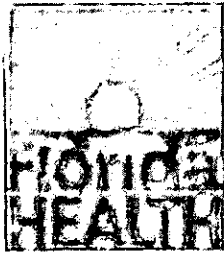
Vascular & Interventional Specialists

The patient's saturations began to drop from approximately 99 to 98% and then to 93%. Nasal oxygen was increased from 2 L to 3 L. Voice translation service was called to help translate as the patient's primary language is Creole. The pt began to complain of pain in the right back/flank area and headache and he appeared anxious. (pre procedure, the patient had complained of headache and "cold-like symptoms; and the patient was taking antibiotics. Heparin 5,000 units, Fentanyl 25mcg iv and Versed 0.5mg iv were administered (to help relieve the anxiety and pain.) The patient's saturations continued to drop, however, to approximately 90-89%. Oxygen was increased to 4 L via nasal cannula. The pt stated pain he was better and he was "good" after the pain meds. Pt continued to seem anxious; and his saturations continued to decrease. The patient was responsive but nonverbal with his eyes open. He began shaking and his hands were also very cold. The decision was made at this time to end the procedure and call 911. The saturations then went from 86% on 4 L nasal cannula to 68%. At that point we began assisted manual ventilations with a bag mask. The pt was tachycardic with high blood pressure. EMS arrived within 5 minutes; and they were given report by the physician. EMS checked the patient's blood sugar which was 178 mg/dl. The pt was responsive and his O2 saturations were 97% on a non-rebreather mask when leaving the facility for transfer to Orlando Regional Medical Center Emergency Room.

Initial discussion with the ER physician indicated concerns for a RML infiltrate/pneumonia – based upon admission CXR findings; and the patient was stable. However following a CT, performed later, bilateral PE's were found.

Follow up on 01/26/2015 revealed that the patient is stable and doing well on 3 L nasal cannula. A temporary femoral catheter was placed at the hospital; and the patient received dialysis. The patient is on a Heparin drip and Coumadin was started; awaiting vascular consult and therapeutic INR.





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

Gynecologic + Gynecology Asso. of Central Florida
Name of office

Kissimmee 34744 Osceola
City Zip Code County

Dr. Juan Reinoso M.D.
Name of Physician or Licensee Reporting

Patient's address for Physician or Licensee Reporting

2400 N. Orange Blossom Trail Suite 300
Street Address

4078407200
Telephone

ME00741103
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted]
Patient Name

[Redacted]
Patient's Address

2964284
Patient Identification Number

Polyp - cervical
Diagnosis

[Redacted] Female
Age Gender

1/23/15
Date of Office Visit

Pelvic / Breast exam
Purpose of Office Visit

602.7
ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

1/23/15 Approx. 11Am
Incident Date and Time

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

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

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

See Attached detail Report

B) ICD-9-CM Codes

6022.7

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)

sterile Speculum, tenaculum, Dilator, Hysteroscope

D) Outcome of Incident (Please check)

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

Outcome of transfer – e.g., death, brain damage, observation only N/A

Name of facility to which patient was transferred:

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:

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

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

Juan Reinoso ME00741103, Physician, performed procedure

Jessica Sanchez medical Assistant, worked up patient + Assisted physician

Katie Smith Practice Administrator, Brought patient in Room

upon 2nd arrival + informed physician pt was back.

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)

See Attached

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

See Attached

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

Dr. Juan Reinoso
ME00741103
LICENSE NUMBER

11/30/15

9:00AM

DATE REPORT COMPLETED

TIME REPORT COMPLETED

Physician Office Adverse Incident Report

Date: 1/30/2015

Patient Name: [REDACTED]

Location: 2400 N. Orange Blossom Trail Suite 300 Kissimmee, FL 34744

Gender: Female

Age: [REDACTED] Years Old

Diagnosis: Polyp/Annual Exam

Date of Office Visit: 1/23/2015

Purpose of Office Visit: Pelvic Breast Exam

Physician: Dr. Juan Reinoso ME0074163

My medical Assistant, Jessica Sanchez, went to the waiting room on 1/23/2015 around 11am to call for our next patient by the name of [REDACTED]. A patient stood up and walked to meet the medical assistant at the door. My medical assistant greeted this patient and proceeded to take her back to our procedure room. Since the patient spoke only Spanish, my medical assistant asked in Spanish if she had taken her prescribed medication and confirmed that she was here for the hysteroscopy procedure. The patient responded with a "yes." The patient's vital signs were taken and the patient was asked to remove her pants and underwear and was given a drape. I entered the procedure room and greeted the patient by name in Spanish. I reviewed the steps of the procedure. I showed her the equipment that would be used and I also pointed out the monitor through which she could see the procedure being performed if she so desired. I asked her if she had any questions and she answered with a "no." We then began the hysteroscopy in the usual sterile fashion after placing local anesthesia (a paracervical block was performed with cc of 1% lidocaine). I saw 2 polypoid masses each approximately 1.5cm obscuring the os of the cervix. These were removed easily with a ring forcep. We continued in the usual fashion and the procedure was uneventful. I showed the patient the vial that contained the 2 masses that were removed. I told her that these masses were the most likely reason for her bleeding abnormality. I also told her that the rest of the exam did not display any other obvious abnormalities and that the biopsies were obtained. She sat up without any difficulty and stated that she felt fine. I reviewed with her the common things that she could experience after the procedure. She had no questions and I instructed her to make a follow up appointment in 2 weeks.

Shortly after the patient left, my medical assistant informed me that the patient we had just performed the hysteroscopy was not Miss [REDACTED] but another patient by the name of [REDACTED]. I asked Miss [REDACTED] and her family members to come into my office. I explained the situation and apologized. I told them that I did not understand why Miss [REDACTED] responded when we called for Miss [REDACTED]. The family

members also seemed confused and did not know as to why she responded to Miss [REDACTED] name being called. At the time her name had been called the family members were not with her because they also had appointments and were already in other exam rooms. I did explain to them that had we performed an annual exam, I would not have been able to perform a pap smear since these masses were obscuring the opening of the cervix and that I would have recommended the exact procedure that she underwent. The family members were obviously upset at the situation and stated that they would not be coming back to this practice. I told them that I understood, but that it was very important to have at least a follow up to review the pathology report of these masses in about a week. They left my office continuing to express very loudly derogatory comments about me and my office. I was later informed that this continued in the patient waiting room.

Several minutes later my office manager pulled me from one of my patient rooms to inform me that Miss [REDACTED] was not feeling well and was put in my office. I asked that she be placed in an exam room and that her vitals, blood sugar and hemoglobin be taken. I went to the room to examine her and found her very agitated and upset. Her blood pressure was elevated. I told her to take an extra dose of her hypertensive medication and rest once she got home. If her symptoms did not resolve in 2 hours I encouraged her to call us, see her primary care physician or to go to the ER. I also encouraged all her family members to calm down at least for her sake because it was at least obvious to me that all the heated emotions were affecting the patient. By the time they left the office the patient was better.

After approximately 5 days, I received the pathology report indicating that the masses that had been removed were benign endocervical polyps. The rest of the biopsies were negative. I called the patient at home and informed her of the results.

This whole situation was very confusing and unfortunate. After the patient left, we did have an opportunity to inquire with Miss [REDACTED] as to why she did not respond when her name was called. She explained that she suffers with anxiety and began experiencing this while in the waiting room. It appears that just before her name was called she stepped out of the office to meet with her son downstairs and also to go to the rest room. Due to the commotion and the comments that the [REDACTED] family made in the waiting room she decided to cancel her procedure.

It is important to note that both Miss [REDACTED] and Miss [REDACTED] are similar in age and height. Additionally, all conversations with Miss [REDACTED] were had in Spanish, her primary language. At no point did Miss [REDACTED] indicate that she was having difficulty communicating or understanding any of the topics or issues addressed during the visit.

Finally, this situation has never occurred in our practice before. However, after this event occurred, we had several meetings with all individuals involved and have taken action to prevent this from ever happening again. First, we have initiated an aggressive attempt to utilize picture identification for all patients of the practice. Specifically, patients will be required to have their photo taken and entered into our EMR system, which already has this feature in place. Additionally, once the patient is brought to the examination and/or procedure room, and prior to any other instruction or questioning, all office

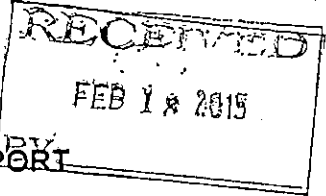
employees and staff have been instructed to ask the patient their name and date of birth to once again confirm their identify.

Thank you very much for your time and consideration.

Juan Reinoso, MD



201506556-167
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

Ear Nose and Throat Associates of South Florida
Name of office

Wellington 33414 Palm Beach
City Zip Code County

Suresh Raja, MD
Name of Physician or Licensee Reporting

Patient's address for Physician or Licensee Reporting

1395 State Road 7, #350
Street Address

561 793-3363
Telephone

ME72337, OSR 998
License Number & office registration number, if applicable

II. PATIENT INFORMATION

[Redacted]
Patient Name

[Redacted]
Patient's Address

GW ID# 1184772

Macroglossia 750.15
Patient Identification Number
Diagnosis

[Redacted] Female
Age Gender

2-2-15
Date of Office Visit

Radio frequency ablation
Purpose of Office Visit

EPT 41530, Dx code 750.15
ICD-9 Code for description of incident

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

III. INCIDENT INFORMATION

February 2, 2015
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 additional sheet

B) ICD-9-CM Codes

415.30 478.25 nla
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)

Arthrocare coblation machine

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure.
<input type="checkbox"/> Surgical procedure performed on the wrong patient.	** if it resulted in:
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure.	<input type="checkbox"/> Death
<input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a hospital.	<input type="checkbox"/> Brain Damage
Outcome of transfer – e.g., death, brain damage, observation only <u>intubation, observation</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred: <u>Wellington Regional Medical Center</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.

Suresh Raja, MD, ME 72337 - Physician performing procedure

Danielle Garrett, LPN, ME 54733 - Assistant during procedure

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

Noritza Cajete, Medical Assistant

IV. ANALYSIS AND CORRECTIVE ACTION

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

Please see additional form

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

Please see additional form

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 72337
LICENSE NUMBER

2/10/15
DATE REPORT COMPLETED

11:30am
TIME REPORT COMPLETED

B) ICD-9-CM Codes

41530 478.25 nla
 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)

Arthrocare coblation machine

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>intubation, observation</u> Name of facility to which patient was transferred: <u>Wellington 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.
---	---

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.

Suresh Raja, MD, ME 72337 - Physician performing procedure
Danielle Garrett, LPN 5217313 - Assistant during procedure

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

Norritza Cajete, Medical Assistant

IV. ANALYSIS AND CORRECTIVE ACTION

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

Please see additional form

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

Please see additional form

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 72337
 LICENSE NUMBER

2/10/15
 DATE REPORT COMPLETED

11:30am
 TIME REPORT COMPLETED



Ear, Nose and Throat Associates of South Florida, P.A.

Caring For Our Patients Since 1963

www.entsf.com

Neil G. Goldhaber, M.D.

Board Certified, American Board of Otolaryngology

Suresh Raja, M.D.

Board Certified, American Board of Otolaryngology


2-10-15

[REDACTED]
[REDACTED]

Mrs. [REDACTED] underwent a local sedation radiofrequency ablation of the tongue base/soft palate in my office procedure room on 2/2/2015.

After the patient consented to proceed with the procedure, it was during last lesion placement into the right paramedian soft palate, a significant soft palate hemorrhage occurred from the puncture site associated with a rapid onset palatal edema. I called EMS immediately, cauterized her puncture site and applied compressive pressure. Upon arrival of the EMS, the airway was deemed stable by myself and the EMS confirmed through an in office fiberoptic exam. Her BP was noted to be high 190/110 at the time of the hemorrhage and she was emergently transferred to Wellington ER. She did have a 2 day hospital stay in the ICU for airway management as she did require intubation within 2 hours of arriving in the ER. She was extubated the next day and was subsequently seen in the office on 2/9/15. She was doing well and will follow up in my office in 7-10 days.

Professionally,


Suresh Raja, M.D.



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

Gulf Coast Obstetrics & Gynecology of Sarasota, LLC
Name of office Street
Sarasota 34239 Sarasota
City Zip Code County
Deanna Doyle, MD
Name of Physician or Licensee Reporting
1950 Arlington Street, Suite 203, Sarasota, FL 34239
Patient's address for Physician or Licensee Reporting

1950 Arlington Street, Suite 203

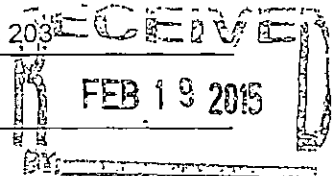
Address

941-379-6331

Telephone

ME70523 / OSR852

License Number & office registration number, if applicable



II. PATIENT INFORMATION

Patient Name
Patient's Address Date EMR Chart Number
845050
Patient Identification Number Purpose
Uterine Fibroids 218.9
Diagnosis ICD-9
Level

Age

F Gender ☐ Medicaid ☐ Medicare

02-05-2015

of Office Visit

of Office Visit
Treatment of Fibroids

Code for description of incident

of Surgery (II) or (III)

III. INCIDENT INFORMATION

February 5, 2015 at 14:10

Incident Date and Time

Location of Incident:

☐ Operating Room

☐ Recovery Room

☒ Other Office

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

Was an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

year old woman underwent myosure procedure for uterine fibroids which was uneventful. Prior to discharge, uterine bleeding was noted and estimated to be 300-400ml. The patient was asymptomatic with stable vitals signs. A foley catheter balloon was placed into the uterus to achieve adequate hemostasis, the patient was transferred to Sarasota Memorial Hospital for observation. She did well and was discharged the next day.

B) ICD-9-CM Codes

218.9

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

585.61

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)

Myosure Device

D) Outcome of Incident (Please check)

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

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

- ☐ Surgical procedure performed on the wrong site **
- ☐ Wrong surgical procedure performed **
- ☐ Surgical repair of injuries or damage from a planned surgical procedure.
- ** if it resulted in:
 - ☐ Death
 - ☐ Brain Damage
 - ☐ Spinal Damage
 - ☐ Permanent disfigurement not to include the incision scar
 - ☐ Fracture or dislocation of bones or joints
 - ☐ Limitation of neurological, physical, or sensory function.
 - ☐ Any condition that required the transfer of the patient 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.

Jay Epstein, MD (Anesthesiologist) ME70773
Leanna Surochak, RN (Recovery RN) RN9243279
Deanna Doyle, MD (OB/Gyn) ME70523

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

Buffy Benoit, LPN

IV. ANALYSIS AND CORRECTIVE ACTION

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

This is a known potential complication of the procedure.

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

Development of additional protocols for post-procedure bleeding including the creation of a 'hemorrhage kit'.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 70523
LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA1030-12/06
Page 2 of 2

Patient Identification Number
ESKD
Diagnosis

Purpose of Office Visit

ICD-9 Code for description of Incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2-5-15 @ 1415
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. in SUPINE POSITION PREPARED FOR FISTULOGRAM PROCEDURE. PT. STATES SHE'S NAUSEATED & SPAT ORAL SALIVA. 20PM 4 1/2 IV. PT. HAS RECEIVED VERSED 2 1/2 & FENTANYL 50 MCG BUT GUTE AREA 0 X 3. PT. STATED REVEIT. FROM NAUSEA & WE RESUMED LIGHT SEDATION & VERSED 1mg + FENTANYL 50 MCG & 1000 10 & PROPOL 20 MCG. PT'S HR ↑ 150S & N & V. LABETALOL 15 MCG IV HR ↓ 90S. BP 170/80 NO COMPLAINT OF SOB & CP. PT. AWARE & ADVISED TO GO TO HOSPITAL FOR REEVALUATION. N/A CASE CANCELLED

B) ICD-9-CM Codes

ESRD - fistulogram

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>Sarasota 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.

Isabel Cordero CRNA

Mike Nitarski MD

A. Prasad MD

Christina Webber

Valerie Knowlton

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)

Due to Tachycardia the procedure was not started and patient was transferred to

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

hospital for further work

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

2-5-15

DATE REPORT COMPLETED

1500
TIME REPORT COMPLETED

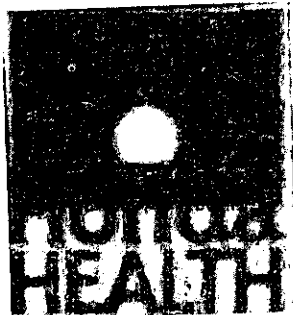
LICENSE NUMBER

ME 115578

201506381-173

STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

FEB 18 2015

SUBMIT FORM TO:

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

I. OFFICE INFORMATION

Vein & Vascular Center of South Florida

Name of office

Hollywood 33021 Broward

City

Zip Code

County

Dr. David Feldbaum

Name of Physician or Licensee Reporting

Patient's address for Physician or Licensee Reporting

Street Address

4700 Shandon Street

Telephone

954 381 7300

License Number & office registration number, if applicable

OSR 953

II. PATIENT INFORMATION

Patient Name

Patient's Address

Patient Identification Number

Diagnosis

Age

01/16/15

Gender

Female

Medicaid

Medicare

Date of Office Visit

angiogram

Purpose of Office Visit

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

* hematoma

III. INCIDENT INFORMATION

Incident Date and Time

01/16/15

Location of Incident:

☐ Operating Room☒ Recovery Room☐ OtherNote: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ NoA) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

had an angiogram with left lower extremity intervention on 01/16/15, Dr. Feldbaum accessed left popliteal artery, angiogram with left SFA intervention was performed. PTA closure device was deployed by Dr. Feldbaum, pressure held & dressing applied without incident. -> see attached.

Narrative Note: 01/16/15

Name: [REDACTED]

Date: 01/16/15

ALDRETE SCORE				DISCHARGE	
Add up the total from each of the five areas scored (Max score = 10)					
SCORE	CRITERIA	ADM	DISCH		
Activity Level	Moves 4 extremities voluntarily/on command Moves 2 extremities No movement of extremities			A. IV Intake _____ PO Intake _____ Urine Output _____	
Respiration	Breathes deeply and coughs freely Dyspnea with shallow/limited breathing Apnea			B. IV D/C at _____ Site Assessment _____	
Circulation	20mm Hg > preanesthetic state 20-50 mm Hg > preanesthetic level 50mm Hg > preanesthetic level			C. Cath Intact _____	
Consciousness	Fully awake, alert Drowsy, arousable to oriented state Not responsive			D. Ambulated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
O2 Saturation	Level >92% on room air Requires oxygen to maintain level >92% Level <92% with oxygen supplement			E. Gait Steady _____ Dressed Self _____	
Total: (must be 9 or greater prior to discharge)				F. Condition at time of release _____	
Assessment by: _____				Discharged to care of _____	
				Does the patient report pain at present time _____	
				Scale _____ [pain scale] See page 1	
				Post Procedure/Discharge Instruction/Teaching to: _____	
				<input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Copy Given	
				<input type="checkbox"/> Discharge Criteria Met @ _____	
				Discharged Approved: _____ M.D.	
				<input type="checkbox"/> Feldbaum <input type="checkbox"/> Fonseca	
				Signature: _____ R.N./A.R.N.P.	
				Date: _____ Time: _____ Ambulatory _____ WC _____	

Nurses Notes: MDD: patient c/o pain to lower left leg, swelling noted to left anterior lower leg. Dr. Feldbaum made aware, continue to observe. 1500: pt states pain is decreased, RPT. Monitor left lower leg. 1600: attempted to stand patient up, pt unable to bear wt on left leg due to pain, swelling some decreased. Left lower leg tender to palpation. Dr. Feldbaum called & made aware. Pt taken to bathroom in recliner. 1610: pt stood up in bathroom after having BM, & complained of dizziness. Placed in recliner. bp = 77/48, p = 68 bpm. IV reestablished given 1/2 bolus. 1615 = bp = 102/54, p = 123 bpm. Recliner moved down, pt states she feels better. Dr. Feldbaum made aware of when pt condition, on his way to office. 1620: bp = 125/56, p = 68. 1635: Dr. Feldbaum arrived to examine patient. VSS, pt still having pain to LLS. 1640: Dr. Feldbaum decided to have patient transported to hospital for fasciotomy to relieve pain/swelling. 911 called. 1650: rescue arrived, given report by Dr. Feldbaum. VSS stable. Pt transferred to medical emergency. INV.

See additional nursing notes on back

Form date: 8/22/14

Place labels here:

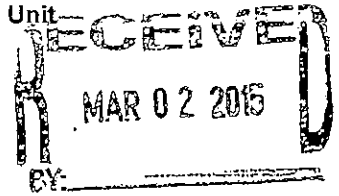


STATE OF FLORIDA
Rick Scott, Governor

201507103-35

**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

First Coast Cardiovascular Institute

Name of office:

Jacksonville 32216

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. South

Street Address

904-493-3333

Telephone

N/A

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Name

Patient's Address
32504

Patient Identification Number
Peripheral vascular disease
Diagnosis

Female ☐ Gender ☒ Medicaid Medicare

Age 02/11/2015
Date of Office Visit
peripheral intervention

Purpose of Office Visit
998.12

ICD-9 Code for description of incident
II

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2/11/2015 2220

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 had small amt of bleeding from right groin and pain control. Pt transferred via amb to Memorial Hospital for obs due to groin bleeding and pain control. Pt discharged to home in stable condition.

B) ICD-9-CM Codes

998.12

E879.9

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)

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>obs only</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred: Memorial Hospital	<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.

Margie Matheny Rn {9395929} Courtney Wall Rn {9303605}

Yasen Khafib md { ME 85393}

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)

peripheral angiography

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

Patient Transfers are being tracked and monitored by staff, physicians, and administration.

V:

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME85393

LICENSE NUMBER

2/24/2015

7 pm

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA1030-12/06

Page 2 of 2

201-507137

35



STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

MAR 02 2015

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

First Coast Cardiovascular Institute

Name of office

Jacksonville

32216

Duval

City

Zip Code

County

Vaqr Ali, MD ME93151

Name of Physician or Licensee Reporting

FCCI Cath Lab

Patient's address for Physician or Licensee Reporting

3900 University Blvd. South

Street Address

904-493-3333

Telephone

N/A

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Name

Patient's Address

MRN 332140

Patient Identification Number

Peripheral Vascular Disease

Diagnosis

FEMALE

☒☐

Age

Gender

Medicaid

Medicare

02/20/2015

Date of Office Visit

Revascularization Right Leg

Purpose of Office Visit

998.12

ICD-9 Code for description of incident

II

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2/20/2015 1545

Incident Date and Time

Location of Incident:

☐ Operating Room☒ Recovery Room☐ OtherNote: If the incident involved a death, was the medical examiner notified? ☐ Yes ☐ NoWas an autopsy performed? ☐ Yes ☐ No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

Sheath was pulled with hemostatis obtained. Pt complained of pain in left lower quadrant and swelling noted

and additional pressure held. Pt transferred to Memorial Hospital via ambulance for stat ct of abd and pelvis to r/o

R/P bleed. Pt monitored and discharged to home 2/24/2015 in stable condition ..

B) ICD-9-CM Codes

998.12

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)

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.	
<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 <u>obs only</u>	<input type="checkbox"/> Brain Damage
Name of facility to which patient was transferred: Memorial Hospital	<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.

Pamela Moore RN(RN 9223294)

Marjorie Matheny RN(RN 9395929)

Janie Jenkins RN (RN 9242170)

Dr.Ali (ME 93151)

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)**

angioplasty of lower extremity for severe PAD

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

All transfers to hospital are being closely monitored and tracked by Cath lab staff and FCCI doctors and administration.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

02/27/2015

DATE REPORT COMPLETED

9 AM

TIME REPORT COMPLETED

ME 93151

LICENSE NUMBER



2015 07161 - 35
STATE OF FLORIDA
Rick Scott, Governor

DOH Consumer Services

MAR 02 2015

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

First Coast Cardiovascular Institute

Name of office

Jacksonville

32216

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. South

Street Address

904-493-3333

Telephone

N/A

License Number & office registration number, if applicable

II. PATIENT INFORMATION

Patient Name

Patient's Address

MRN 265540

Patient Identification Number

Peripheral Vascular Disease

Diagnosis

Female

☒

☒

Age

Gender

Medicaid

Medicare

02/23/2015

Date of Office Visit

Revascularization Left Leg

Purpose of Office Visit

998.12

ICD-9 Code for description of incident

II

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2-23-2015 @2230

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 complained of Nausea/ Vomiting and abdominal pain/tenderness. Patient unable to void. Patient

transferred to Memorial hospital via ambulance for stat CT of abdomen to rule out RP bleed.

C.T. scan was negative & pt d/c home w/in 4 hrs

B) ICD-9-CM Codes

998.12

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.	** 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>Observation Only</u>	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred: Memorial Hospital	<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.

Janie Jenkins, RN (RN 9242170), Philip Avevor (CRT 68800), Cecelia Breeden, RN ()

Yazan Khatib, MD (ME85393)

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)

Peripheral Angiogram with Intervention

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

Patient Transfers are being tracked and monitored by staff, physicians, and administration.

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME85393

LICENSE NUMBER

2-24-2015

6PM

DATE REPORT COMPLETED

TIME REPORT COMPLETED

DH-MQA-1030-12/06

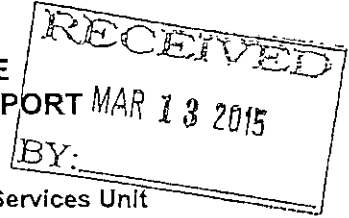
Page 2 of 2



STATE OF FLORIDA
Rick Scott, Governor

201507975-35

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 Associates of Venice and Englewood
Name of office

512 Nokomis Avenue South
Street Address

Venice 34285 Sarasota
City Zip Code County

(941) 486-3491
Telephone

Dr. Sergio L. Selva
Name of Physician or Licensee Reporting

FLME0070607
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

[Redacted]
Patient's Address
177008
Patient Identification Number
195.0, 161.9
Diagnosis

[Redacted] Male ☐ ☒
Age, Gender 2/24/2015 Medicaid Medicare
Date of Office Visit
Purpose of Office Visit Gastrostomy Tube Placement
E870.0
ICD-9 Code for description of incident
2
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

2/24/2015 11:00AM
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)

The patient had a previous gastrostomy. I chose to make a new gastrostomy site medial to the old gastrostomy site in case the patient needed a conversion to a gastrojejunostomy in the future. I had some difficulty dilating the new gastrostomy tract due to scarring. New gastrostomy went in place with no difficulty. When I injected the new gastrostomy tube, I noted a small amount of contrast leak into the peritoneum, but the gastrostomy was in the proper position in the stomach and the patient was stable. I contacted a surgeon, Dr. Bryan Smith, who suggested I give a dose of 300mg Clindamycin IV and place a nasogastric tube to suction and transfer the patient to the hospital through the VRBH ER and admit the patient to the hospitalist service for observation and consult surgery, which I did. I personally escorted the patient on a stretcher across the street to the ER and Dr. Shannon Roberts admitted the patient to the hospitalist service. Later that day, I performed an upper GI series with Gastrografin and the leak had sealed. The patient was admitted for observation for a few days and was discharged home with no leak or perforation.

B) ICD-9-CM Codes

195.0, 161.9
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

E870.0
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)

Suspicion of Microperforation by Kimberly Clark 16French introducer Kit.

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 <u>observation only</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>Venice Regional Bayfront Health</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.

Sergio Selva, MD FLME0070607

Crystal Swenney, RN RN1757182

Robyn Dufrane, RT(R) CRT77901

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)**

I chose to place a gastrostomy medial to the site of the old gastrostomy in case the tube needed to be converted to a gastrojejunostomy in the future. The patient also has scarring from previous gastrostomy site making it difficult to dilate.

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

In the future, when dealing with placing a new gastrostomy in patients with a previous gastrostomy site, I will select a location lateral to and far from the old gastrostomy site to avoid scarring from previous gastrostomy site and minimize risk of perforation.

V.

Sergio Selva
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

FLME0070607
LICENSE NUMBER

2/11/2015
DATE REPORT COMPLETED

1:00 PM
TIME REPORT COMPLETED