

**MEMORANDUM FOR RECONSIDERATION**

TO: Probable Cause Panel  
FROM: Cynthia Shaw, Assistant General Counsel  
RESPONDENT: Melissa Anglero, D.O.  
CASE NO.: 2019-32857  
DATE: August 19, 2020

CS

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This case was presented at the May 1, 2020, probable cause panel meeting, at which time probable cause was found. A two-count administrative complaint was filed charging the Respondent with violating section 459.015(1)(b), and 456.072(1)(w), Florida Statutes.

On or about June 25, 2019, the Virginia Board of Medicine (the licensing authority regulating the practice of osteopathic medicine in Virginia) revoked the Respondent's osteopathic medical license. The respondent failed to update her profile to reflect this out of state discipline. However, the Respondent's license is now null and void.

Based on the foregoing, the Department has brought this matter back before the Panel for reconsideration and requests that the case be dismissed.

**STATE OF FLORIDA  
DEPARTMENT OF HEALTH**

BOARD: Osteopathic Medicine

CASE NUMBER: 2019-32857

COMPLAINT MADE BY: DOH

COMPLAINT MADE AGAINST: Melissa Anglero, D.O.  
400 NE 137<sup>th</sup> Street, Apt. 211  
North Miami, Florida 33161

DATE OF COMPLAINT: July 29, 2020

INVESTIGATED BY: Antoinette F. Carter  
Government Analyst I

REVIEWED BY: Cynthia Shaw CS  
Assistant General Counsel

RECOMMENDATION: Dismiss (4099)

**CLOSING ORDER/NOTICE OF DISMISSAL  
RECONSIDERATION**

THE COMPLAINT: The Complaint alleges that Subject violated sections 4589.015(1)(b) and 456.072(1)(w), Florida Statutes (2018), by having her license to practice osteopathic medicine disciplined by the State of Virginia and by failing to update her profile with said discipline.

THE FACTS: This investigation is predicated upon receipt of information that the Subject's license to practice osteopathic medicine had been disciplined by the Virginia Board of Medicine ("Virginia Board"), the licensing authority regulating the practice of osteopathic medicine in Virginia.

On or about May 1, 2020, the Department filed a two-count administrative complaint against the Respondent, related to this discipline and the fact that Subject had failed to update her Florida practitioner profile with said discipline.

Since that time the Subject's Florida license has become null and void. Accordingly, because the Respondent's license is null and void, the Department recommends that the case be dismissed.

THE LAW: Based on the foregoing, and pursuant to Section 456.073(2), Florida Statutes, the case is hereby DISMISSED.

It is, therefore, ORDERED that this matter should be and the same is hereby DISMISSED.

DONE and ORDERED this \_\_\_\_\_ day of \_\_\_\_\_ 2020.

\_\_\_\_\_  
Chairperson, Probable Cause Panel

PCP Date: October 23, 2020

PCP Members:

CS/crv

**STATE OF FLORIDA  
DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**Petitioner,**

**v.**

**CASE NO.: 2019-32857**

**MELISSA ANGLERO, D.O.,**

**Respondent.**

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**ADMINISTRATIVE COMPLAINT**

Petitioner Department of Health files this Administrative Complaint before the Board of Osteopathic Medicine against Respondent, Melissa Anglero, D.O., and in support thereof alleges:

1. Petitioner is the state agency charged with regulating the practice of Osteopathic Medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 459, Florida Statutes.
2. At all times material to this Complaint, Respondent was licensed to practice osteopathic medicine within the state of Florida, having been issued license number OS 13366.
3. Respondent's address of record is 400 NE 137<sup>th</sup> Street, North Miami, Florida, 33161.

4. Respondent is also licensed to practice osteopathic medicine in the state of Virginia, by the Virginia Board of Medicine (“Virginia Board”), the licensing authority regulating the practice of osteopathic medicine in Virginia, having been issued license number 0102-203052.

5. On or about June 25, 2019, the Virginia Board entered an Order revoking the Respondent’s license to practice osteopathic medicine because she was unable to practice osteopathic medicine with safety to patients and the public as demonstrated by her treatment and care of six patients. She was also found to have answered two questions falsely on her application for licensure in Virginia.

6. The June 25, 2019, Order constitutes action against Respondent’s Virginia license to practice osteopathic medicine.

7. Respondent failed to update her Florida practitioner profile with the action taken against her Virginia Osteopathic medical license within fifteen (15) days of the final disciplinary action.

### **Count I**

8. Petitioner re-alleges and incorporates paragraphs one (1) through six (6), as if set out fully herein.

9. Section 459.015(1)(b), Florida Statutes (2018), provides that having a license or the authority to practice osteopathic medicine revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions, constitutes grounds for discipline by the Board of Osteopathic Medicine.

10. On June 25, 2018, the Virginia Board revoked the Respondent's Virginia osteopathic medical license.

11. Based on the foregoing, Respondent has violated section 459.015(1)(b), Florida Statutes (2018), by having her osteopathic medical license acted against by the osteopathic medical licensing authority of another jurisdiction.

### **Count II**

12. Petitioner re-alleges and incorporates paragraphs one (1) through five (5), and seven (7) as if set out fully herein.

13. Section 456.072(1)(w), Florida Statutes (2018), provides that failing to comply with the requirements for profiling and credentialing, including, but not limited to, failing to provide initial information, failing to timely provide updated information, or making misleading, untrue, deceptive,

or fraudulent representations on a profile, credentialing, or initial or renewal licensure application, constitutes grounds for discipline by the Board of Osteopathic Medicine.

14. Section 456.039(1)(a)(8), Florida Statutes (2018), provides, in relevant part, that failure to report description of any final disciplinary action taken within the previous ten (10) years against the applicant by the agency regulating the profession that the applicant is or has been licensed to practice, whether in this state or in any other jurisdiction, by a specialty board that is recognized by the American Board of Medical Specialties, the American Osteopathic Association, or a similar national organization, or by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home to the department, constitutes grounds for discipline by the Florida Board of Medicine.

15. Section 456.042, Florida Statutes (2018), provides, in relevant part, that a practitioner must submit updates of required information within fifteen (15) days after the final activity that renders such information a fact. An updated profile is subject to the same requirements as an original profile.

16. Respondent violated section 456.072(1)(w), Florida Statutes (2018), by failing to update her practitioner profile with the June 25, 2019, Order by the Virginia Board within fifteen (15) days.

17. Based on the forgoing, Respondent has violated section 456.072(1)(w), Florida Statutes (2018), by failing to timely update her practitioner profile within fifteen (15) days of the final disciplinary action against her osteopathic medical license.

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

*[Signature on the following page.]*

SIGNED this 1<sup>st</sup> day of May, 2020.

Scott A. Rivkees, M.D.  
State Surgeon General and Secretary of Health

*Cynthia Shaw*

**FILED**

DEPARTMENT OF HEALTH  
DEPUTY CLERK

CLERK: *Janice Morris*  
DATE: MAY 01 2020

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Cynthia Shaw, Esq.  
Assistant General Counsel  
Florida Bar Number: 727611  
Florida Department of Health  
Office of the General Counsel  
4052 Bald Cypress Way, Bin C-65  
Tallahassee, Florida 32399-3265  
(P): (850) 558-9817  
(F): (850) 245-4684  
(E): [Cynthia.Shaw@flhealth.gov](mailto:Cynthia.Shaw@flhealth.gov)

PCP Date: April 28, 2020

PCP Members: Glenn Moran, D.O. and Joel B. Rose, D.O.

## **NOTICE OF RIGHTS**

**Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested. A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.**

**Mediation under Section 120.573, Florida Statutes, is not available to resolve this Administrative Complaint.**

## **NOTICE REGARDING ASSESSMENT OF COSTS**

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

**ELECTION OF RIGHTS**

I received the Administrative Complaint on the following date: \_\_\_\_\_

Persons seeking a hearing on an Administrative Complaint must file a petition for hearing with the agency within 21 days of receipt of written notice of the Administrative Complaint pursuant to Rule 28-106.111(2), Florida Administrative Code.

Any person who receives written notice of an Administrative Complaint and who fails to file a written request for a hearing within 21 days waives the right to request a hearing on such matters pursuant to Rule 28-106.111(4), Florida Administrative Code.

**PLEASE SELECT ONLY 1 OF THE 2 OPTIONS.**

OPTION 1. \_\_\_\_\_ I **do not** dispute the allegations of material fact in the Administrative Complaint. I request a hearing be conducted pursuant to Section 120.57(2), Florida Statutes, where I will be permitted to appear, if I so choose, and submit oral and/or written evidence in mitigation of the complaint to the Board.

OPTION 2. \_\_\_\_\_ I **do** dispute the allegations of material fact contained in the Administrative Complaint and request this to be considered a petition for formal hearing, pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes, before an Administrative Law Judge appointed by the Division of Administrative Hearings. **Pursuant to the requirement of Uniform Rule 28-106.2015(5), Florida Administrative Code, I specifically dispute the following material facts (identified by paragraph number and fact disputed) in the Administrative Complaint:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE NOTE:** If the Department does not receive your completed election of rights within 21 days of your receipt of the Administrative Complaint, your request for hearing will be denied.

\_\_\_\_\_  
Respondent's Signature  
Address: \_\_\_\_\_

\_\_\_\_\_  
Attorney/Qualified Representative\*  
Address: \_\_\_\_\_

Lic. No.: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Fax No.: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

**\*Qualified Representatives must file written requests to appear as such pursuant to Rule 28-106.106, Uniform Rules of Procedure.**

PLEASE MAIL AND/OR FAX COMPLETED FORM TO: Cynthia Shaw, Esquire, Assistant General Counsel, DOH, Prosecution Services Unit, 4052 Bald Cypress Way, Bin C-65, Tallahassee, Florida 32399-3265. Telephone Number: (850) 558-9817; FAX (850) 245-4684; TDD 1-800-955-8771; [cynthia.shaw@flhealth.gov](mailto:cynthia.shaw@flhealth.gov)

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

**Vision:** To be the Healthiest State in the Nation

May 1, 2020

Melissa Anglero, D.O.  
400 NE 137th Street, Apt. 211  
North Miami, FL 33161

RE: Department of Health vs. Melissa Anglero, D.O.  
Case No. 2019-32857

Dear Ms. Anglero:

Enclosed please find a copy of an Administrative Complaint that has been filed against your license by the Department of Health. An Election of Rights form is also provided.

Please review the attached documents and return the Election of Rights form to my attention. You **must** sign the Election of Rights form, with your signature notarized, and return the completed form to my office within twenty-one (21) days of the date you received it. Failure to return this form within twenty-one days may result in the entry of a default judgment against you without hearing your side of the case.

Sincerely yours,

*Cynthia Shaw*

Cynthia Shaw, Esquire  
Assistant General Counsel

SC/lt

Enclosures: As listed

Certified Article Number

9414 7266 9904 2151 9155 80

SENDER'S RECORD

**Florida Department of Health**

Office of the General Counsel – Prosecution Services Unit  
4052 Bald Cypress Way, Bin C-65 • Tallahassee, FL 32399-3265  
EXPRESS MAIL: 2585 Merchants Row, Suite 105  
PHONE: 850/245-4640 • FAX: 850/245-4684

**FloridaHealth.gov**



Accredited Health Department  
Public Health Accreditation Board

WALZ  
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FROM

**WALZ**

FORM #45663 VERSION: E0119

Melissa Anglero, D.O.  
400 NE 137th Street, Apt. 211  
North Miami, FL 33161

Label #1

Melissa Anglero, D.O.  
400 NE 137th Street, Apt. 211  
North Miami, FL 33161

Label #2

Department of Health  
Prosecution Services  
4052 Bald Cypress Way  
Bin C-65  
Tallahassee, FL 32399-3265

Label #3

U.S. Postal Service®  
**CERTIFIED MAIL® RECEIPT**

Domestic Mail Only

USPS® ARTICLE NUMBER

9414 7266 9904 2151 9155 80

Certified Mail Fee	\$	3.50
Return Receipt (Hardcopy)	\$	2.80
Return Receipt (Electronic)	\$	0.00
Certified Mail Restricted Delivery	\$	0.00
Postage	\$	0.50
Total Postage and Fees	\$	6.80

Postmark  
Here

TEAR ALONG THIS LINE

Sent to: Melissa Anglero, D.O.  
400 NE 137th Street, Apt. 211  
North Miami, FL 33161

Reference Information

Cynthia Shaw/LT 5.4.2020  
AC Pack 2019-32857 Anglero

PS Form 3800, Facsimile, July 2015

FOLD AND TEAR THIS WAY → OPTIONAL

Label #5 (OPTIONAL)

Department of Health  
Prosecution Services  
4052 Bald Cypress Way  
Bin C-65  
Tallahassee, FL 32399-3265

Label #6 - Return Receipt Barcode (Sender's Record)



9590 9266 9904 2151 9155 83

Label #7 - Certified Mail Article Number

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT  
OF THE RETURN ADDRESS. FOLD AT DOTTED LINE

**CERTIFIED MAIL®**



9414 7266 9904 2151 9155 80

RETURN RECEIPT REQUESTED

FOLD AND TEAR THIS WAY →

FOLD AND TEAR THIS WAY →

Return Receipt (Form 3811) Barcode



9590 9266 9904 2151 9155 83

1. Article Addressed to:  
Melissa Anglero, D.O.  
400 NE 137th Street, Apt. 211  
North Miami, FL 33161

2. Certified Mail (Form 3800) Article Number  
9414 7266 9904 2151 9155 80

COMPLETE THIS SECTION ON DELIVERY

A. Signature  Agent  
**X**  Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1?  Yes  
If YES, enter delivery address below:  No

3. Service Type:  
 Certified Mail  
 Certified Mail Restricted Delivery

Reference Information  
AC Pack 2019-32857 Anglero  
Cynthia Shaw/LT 5.4.2020

Thank you for using Return Receipt Service

RETURN RECEIPT REQUESTED  
USPS® MAIL CARRIER  
DETACH ALONG PERFORATION

Thank you for using Return Receipt Service

Return Receipt (Form 3811) Barcode



9590 9266 9904 2151 9155 83

1. Article Addressed to:  
Melissa Anglero, D.O.  
400 NE 137th Street, Apt. 211  
North Miami, FL 33161

2020 MAY 27 PM 12:11  
PRACTITIONER REGULATION  
LEGAL

2. Certified Mail (Form 3800) Article Number  
9414 7266 9904 2151 9155 80

COMPLETE THIS SECTION ON DELIVERY

A. Signature  Agent  
 Addressee

B. Received by (Printed Name) C. Date of Delivery  
E. J. COVIDA 5-26

D. Is delivery address different from item 1?  Yes  
If YES, enter delivery address below:  No

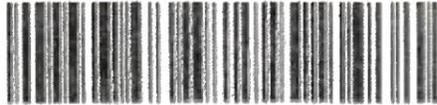
3. Service Type:  
 Certified Mail  
 Certified Mail Restricted Delivery

Reference Information  
AC Pack 2019-32857 Anglero  
Cynthia Shaw/LT 5.4.2020

PS Form 3811, Facsimile, July 2015

Domestic Return Receipt

USPS TRACKING #



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DEPARTMENT OF HEALTH  
2585 MERCHANTS ROW  
TALLAHASSEE FL 32399



STATE OF FLORIDA



DEPARTMENT OF HEALTH

INVESTIGATIVE REPORT

Office: Consumer Services Unit	Date of Complaint: 07/29/2019	Case Number: 2019-32857
Subject: MELISSA ANGLERO, D.O. 400 NE 137 <sup>th</sup> Street, Apt. 211 North Miami, FL 33161 (954) 899-4763	Source: FLORIDA DEPARTMENT OF HEALTH/ LICENSURE SUPPORT SERVICES	
Profession: Osteopathic Physician	License Number and Status: 13366 – DELINQUENT/ACTIVE	
Related Case(s): None	Period of Investigation and Type of Report: 07/29/19- 07/29/19 FINAL	
Alleged Violation: SS. 456.042; 456.072(1)(k)(d), 459.015 (1)(b)(g)(PP), F.S. Violate Statute / Rule of Board; Failure to perform legal obligation; Failure to report violation; License disciplined by federal/other state; Failure to update practitioner profile		
<p>Synopsis: This investigation is predicated upon receipt of a complaint from the FLORIDA DEPARTMENT OF HEALTH/LICENSURE SUPPORT SERVICES alleging ANGLERO's license was disciplined by the Virginia Board of Medicine on 06/25/19. Disciplinary documents from Virginia Board of Medicine show that ANGLERO's license was revoked due to her incompetence to practice osteopathy and surgery with safety to patients and the public while employed as a physician at an obstetrical-gynecological (OB/GYN) practice in Virginia from 08/01/12-04/01/15. ANGLERO failed to update her Florida practitioner profile to reflect this disciplinary action (Ex. #1).</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Subject Notification Completed?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Subject Responded?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Patient Notification Completed?  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Above referenced licensure checked in database/LEIDS?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Board certified? Name of Board: Date:  Specialty:</p> <p>Law Enforcement  <input type="checkbox"/> Notified Date:  <input type="checkbox"/> Involved Agency:</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Subject represented by an attorney?  Attorney information:</p>		
Investigator/Date:  Antoinette F. Carter HA 115 07/29/2019 Government Analyst I	Approved By/Date:  Donna L. Howell Senior Management Analyst II	
Distribution: CSU/PSU		Page 1

TABLE OF CONTENTS

I. INVESTIGATIVE REPORT COVER .....1

II. TABLE OF CONTENTS .....2

III. INVESTIGATIVE DETAILS.....3

Interviews:

IV. EXHIBITS

1. Case Summary, initiating documents..... 4-25

2. Copy of Notification letter, dated 07/29/19 .....26

\* Exhibits contain information which identifies patient(s) by name and are sealed pursuant to section 456.057(9)(a) Florida Statute.

\*\*\*This exhibit contains confidential records concerning reports of abuse, neglect or exploitation of the vulnerable adult, including reports made to the central abuse hotline, and is sealed pursuant to section 415.107(1), Florida Statutes

INVESTIGATIVE DETAILS

STATEMENT OF FLORIDA DEPARTMENT OF HEALTH/LICENSURE SUPPORT SERVICES--

This investigation is predicated upon receipt of a complaint from the FLORIDA DEPARTMENT OF HEALTH/LICENSURE SUPPORT SERVICES alleging ANGLERO's license was disciplined by the Virginia Board of Medicine on 06/25/19. Disciplinary documents from Virginia Board of Medicine show that ANGLERO's license was revoked due to her incompetence to practice osteopathy and surgery with safety to patients and the public while employed as a physician at an obstetrical-gynecological (OB/GYN) practice in Virginia from 08/01/12-04/01/15. ANGLERO failed to update her Florida practitioner profile to reflect this disciplinary action.

STATEMENT OF MELISSA ANGLERO, D.O.--

ANGLERO has failed to respond to this investigator by the date of this report.

## CASE SUMMARY

### CONFIDENTIAL

**Case No: 201932857**

Please use this number in all correspondence with the Department concerning this matter.

**RESPONDENT INFORMATION**

License: 13366 Profession: 1901 Osteopathic Physician  
Name: DR. MELISSA NMN ANGLERO  
Address: 400 NE 137TH STREET  
APT 211  
NORTH MIAMI, FL 33161  
Home Phone: 954-899-4763

**SOURCE OF INFORMATION**

Name: Department Of Health/Licensure Support Services  
Address:

Home Phone:

**REPORTED INFORMATION**

Receive Date: 07/29/2019 Source Code: 5 Form Code: 2  
Responsible Party: ha115 Status Code: 10  
Classification Code: Incident Date: 06/25/2019

Patient Name:

Possible Code(s): 18 , 11 , 37 , 75 , 15

**Summary:**

Possible Violation SS. 456.042, 456.072(1)(k)(x)(d), 459.015(1)(b)(g)(pp) F.S.  
Violate Statute / Rule of Board; Failure to perform legal obligation; Failure to report violation; License disciplined by federal/other state; Failure to update practitioner profile

Internally generated information from Licensure Support Services regarding report of discipline from NPDB not reported. Licensure Services received information regarding an adverse action to Subject's Virginia Osteopathic license. The Subject's license was revoked on 06/25/19 due to her incompetence to practice osteopathy and surgery with safety to patients and the public while employed as a physician at an obstetrical-gynecological (OB/GYN) practice in Virginia from 08/01/12-04/01/15. The Subject failed to update her Florida practitioner profile to reflect this disciplinary action.  
Antoinette Carter HA115

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

**Vision:** To be the Healthiest State in the Nation

## MEMORANDUM

**DATE:** July 26, 2019  
**TO:** Department of Health/Consumer Services Unit  
**FROM:** Licensure Support Services  
**RE:** Report of Discipline from NPDB not reported

Licensure Support Services received the following information regarding an adverse action to the license.

**Name:** Melissa Anglero  
**Profession:** Osteopathic Physician  
**License Number:** OS-13366  
**Reporting Entity:** DHP OF VA ACTION  
**Action Date:** 06/25/2019  
**Action Description:** Agency action: Revocation; Renewal Right Denied, Virginia  
**State/Entity:** Virginia

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**Scott A. Rivkees, MD**  
State Surgeon General

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July 26, 2019

Melissa Nmn Anglero  
400 Ne 137th Street  
Apt 211  
North Miami, FL 33161

RE: OS13366

Dear Dr. Anglero:

As a designated health care professional, you are required by law to furnish certain information to the Department of Health. See §§ 456.039 and 456.042, Fla. Stat. The Department has received notification from the Healthcare Integrity and Protection Data Bank that disciplinary action has been taken against you in another jurisdiction. Our records indicate that you have not notified the Department and your practitioner profile has not been updated with this information as required. Failure to provide the required information 15 days after the final activity that renders such information a fact constitutes a ground for disciplinary action under your licensing chapter and § 456.072(1)(k), Fla. Stat.

You can verify the information about the disciplinary action referenced above on the data bank's home page at [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov). Select the "Perform A Self-Query" option from the "Quick List" menu. The self-query response will give you specific facts you will need to update your practitioner profile, including:

- Who the action was taken by;
- The date the action was taken;
- A description of the action taken;
- A description of the discipline violation;
- If the action is currently under appeal.

Updates to your practitioner profile can be made online at [www.flhealthsource.gov](http://www.flhealthsource.gov). Instructions are enclosed. Failure to provide the information and update your practitioner profile will be reported to the Department's enforcement unit for further action. Please call our office at (850) 488-0595 if you have questions or need additional information.

Sincerely,

Cassandra Williams  
REGULATORY SPECIALIST II  
Licensure Support Services Unit

Enclosure

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## Steps to Update Your Online Practitioner Profile

Please go to [www.FLHealthsource.gov](http://www.FLHealthsource.gov).

1. If you have not created an online account through our new MQA Online Services Portal, please see #5. If so, proceed below.
2. Once on the above site, please select **"Login"** from the top right of the webpage.
3. Click on **"Yes"** to **"Have You Renewed or Applied Online Since 2015?"** Login under **"Returning User"** with your User ID and password.
4. You will be taken to **"My Dashboard"** page where you will select the **"Choose an Activity"** dropdown under **"Manage my License."** Select **"Review, Update & Confirm Profile"** to make changes to your practitioner profile.
5. Go to [www.FLHealthsource.gov](http://www.FLHealthsource.gov).
6. Click on **"Login"** at the top right of the webpage.
7. On the screen that asks **"Have You Renewed or Applied Online Since 2015?"** click **"No."**
8. Please read the information on the next screen. At the bottom of the screen, if you are ready to begin the registration process, click the blue button that states **"Register."**
9. The next screen is the registration page. Click on the **"Register Now"** link. Fill in the required information. Note: When creating your user id, it is recommended you use your email address as your user id. **"Select "Next"**.
10. Once you complete the registration process, a temporary password will be automatically sent to the email address that was used to register.
11. Please retrieve the temporary password from your email account. Then return the MQA Online Services Portal login screen (Link: <https://mqaonline.doh.state.fl.us/datamart/login.do>.)
12. Enter your User ID and temporary password under **"Returning User"** to login to the Portal for the first time. When the system asks for an **"old password"**, it is referring to the temporary password.
13. You will then be prompted to create a new password. Please be sure that the new password you create contains the requirements listed on the screen. (note: password is case sensitive)
14. Once you are logged in, the system will begin the license linking process. Select **"yes"** that you have a current license with the department.
15. Select your profession and license type from the drop down menu.
16. You will be required to enter your social security number, date of birth, and your mailing address zip code that is on file with the Department of Health. Enter the information by selecting Option **"A"** if you know your license number to be linked or Option **"B"** if you don't.
17. Enter the characters from the picture as shown below the screen.
18. You will see your license information on the next screen and select **"yes"** to confirm the information.
19. Once the license is successfully linked, the system will take you to **"My Dashboard"** page.

If you experience difficulties at any point while registering your account, please try viewing our Frequently Asked Questions page or the Video Guide. The link to both resources are below for convenience.

FAQ Page: <http://flhealthsource.gov/mqa-services-faqs>

Video Guide: <http://flhealthsource.gov/video-guide>



...to promote and protect the health and safety of all Floridians.

**Florida's health**  
THE FLORIDA DEPARTMENT OF HEALTH

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**NPDB Reports for Profession: Osteopathic Physician**  
License number: 13366 Name:  
**MELISSA ANGLERO**

**NPDB - Adverse Action Report**

REPORTING ENTITY	ACTION DATE	ACTION LENGTH	ACTION DESCRIPTION	CLASS CODE
NC MEDICAL BOARD	03/02/2017	Indefinite	On March 2, 2017, Dr. Melissa Anglero inactivated her North	Other Licensure Action - Not Classified, Specify
DHP OF VA ACTION	06/25/2019	Indefinite	Agency Action: Revocation; Renewal Right Denied. Virginia	Revocation of Licensure

**COMPAS Discipline**

DISCIPLINE TYPE	DISCIPLINE DATE	DISCIPLINARY ACTION	DISCIPLINARY BODY	VIOLATION	UNDER APPEAL	DISCIPLINARY ACTION INDICATOR	PUBLISHABLE	PROFESSIONAL COMPETENCY	DELIVERY OF SERVICES
LICENSING AGENCY	03/02/2017	Inactivation of License	North Carolina Medical Board	REPORTED TO NATIONAL DATA BANK	Y	Y	N		
ENTITY NAME	10/01/2014	SUSPENDED STAFF PRIVILEGES	CHESAPEAKE REGIONAL MEDICAL CENTER		N	Y	N		
ENTITY NAME	06/30/2015	SUSPENDED STAFF PRIVILEGES	Chesapeake Regional Medical Center	FAILURE TO COMPLY WITH CONTRACTUAL OBLIGATIONS	N	Y	N		

**NPDB - Medical Malpractice Report**

REPORTING ENTITY	ACTION CODE1	ACTION DATE1	ACTION CODE2	ACTION DATE2	SETTLEMENT DATE	AMOUNT PAID
THE DOCTORS' COMPANY	Action Code Not Found	01/25/2017			01/25/2017	225000.00

**COMPAS Closed Claims**

COMPLAINT NUMBER	RSD RECORD ID	COUNTY	CASE NUMBER	DATE RECEIVED	SETTLEMENT DATE	SETTLEMENT AMOUNT
201704576	106580490	OUT OF STATE	710CL 15009126-00	10/31/2014	02/15/2017	800000.00

**NPDB Judgment or Conviction Report**

**\*\*NO RECORDS FOUND\*\***

**BEFORE THE VIRGINIA BOARD OF MEDICINE**

**IN RE: MELISSA ANGLERO, D.O.**  
**LicenseNumber: 0102-203052**  
**Case Number: 154422, 157265, 179140**

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**ORDER**

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**JURISDICTION AND PROCEDURAL HISTORY**

Pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11), a panel of the Virginia Board of Medicine (“Board”) held a formal administrative hearing on June 14, 2019, in Henrico County, Virginia, to inquire into evidence that Melissa Anglero, D.O., may have violated certain laws and regulations governing the practice of osteopathy and surgery in the Commonwealth of Virginia.

Melissa Anglero, D.O., appeared at this proceeding and was represented by Rodney S. Dillman, Esquire.

Upon consideration of the evidence, the Board adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

**FINDINGS OF FACT**

1. On February 8, 2012, the Board issued License Number 0102-203052 to Melissa Anglero, D.O. to practice osteopathy and surgery in the Commonwealth of Virginia. Said license expired on June 30, 2018. At all times relevant hereto, said license was in full force and effect.

2. Melissa Anglero, D.O., is incompetent to practice osteopathy and surgery with safety to patients and the public, as evidenced by her conduct, care, and treatment of Patients A – F and other patients while employed as a physician at an obstetrical-gynecological (“OB/GYN”) practice and practicing at a hospital, both in Chesapeake, Virginia, from approximately August 1, 2012 to April 1, 2015.

a. Patient B was a 29-year-old first time mother who Dr. Anglero treated at the hospital from December 10 – 19, 2012. During that time Patient B underwent an unscheduled hysterectomy following Dr. Anglero's performance of a Kiwi vacuum-assisted delivery.

i. On the evening of December 10, 2012, Patient B, who was assessed on December 3, 2012 with a uterus larger than gestational age and on December 6, 2012 with polyhydramnios, presented to the hospital at approximately 39 weeks' gestation for labor induction with Cervidil (C-VI), with Dr. Anglero as her admitting and attending physician.

ii. At approximately 9:00 a.m. on December 11, 2012, Dr. Anglero ordered the removal of Cervidil and the administration of Pitocin (C-VI) approximately 38 minutes later. At 11:50 a.m., the labor and delivery nurse performed a vaginal exam, noting 5 cm dilation, 90% effacement, a thin cervix and -1 station. At 12:15 pm, the fetal heart rate ("FHR") was non-reactive and at 12:30 p.m., there was a continued non-reactive FHR monitoring strip with absent accelerations and variable decelerations. At 12:34 p.m., Dr. Anglero was at Patient B's bedside and noted that, with a FHR in the 90 bpm range, Patient B pushed for approximately six minutes against advice, after which Dr. Anglero noted (at 12:40 p.m.) that Patient B was fully dilated, at 0 station with 100% effacement, and advised the patient to begin pushing again. Dr. Anglero then noted that Patient B was pushing ineffectively, and that the FHR remained in the upper 90 to lower 100 bpm range with little or no noted improvement with fetal scalp manipulation or after Patient B was administered oxygen. After four applications of the Kiwi vacuum, at 12:54 p.m. Dr. Anglero delivered an eight pound, six ounce infant with shoulder dystocia. The Board heard testimony from a physician present during later treatment of Patient B that the vacuum should not have been used with the patient presenting at 0 station.

iii. Following delivery of the infant, Dr. Anglero attempted to control Patient B's post-delivery bleeding for approximately 37 minutes, including by attempting to repair a fourth-degree episiotomy, deep cervical lacerations, and multiple bilateral vaginal lacerations, but was unsuccessful in her attempts. She stated she was unable to adequately visualize the lacerations while the patient continued bleeding excessively. Dr. Anglero estimated the blood loss at that time to be 650cc, causing her to order a transfusion. While Dr. Anglero was massaging Patient B's uterine fundus and performing a bimanual examination, another OB/GYN physician from Dr. Anglero's office ("Physician 1," senior physician and practice owner) entered the labor and delivery room, saw the significant blood loss, and stated that Patient B needed to be immediately transported to the operating room ("OR").

iv. In the OR, Patient B was placed in the lithotomy position, administered anesthesia, and assessed vaginally. Dr. Anglero noted multiple bilateral vaginal lacerations, including a fourth degree laceration, as well as friable vaginal tissue. She further noted that the lower uterine segment, including the cervix, would not firm up, and that blood gushed out. Vaginal sutures would not hold and Patient B's vagina was packed. One hour after arriving at the OR, Physician 1 called for a hysterectomy and called a third OB/GYN physician ("Physician 2") into the room for a second opinion. Physician 2 opined that Patient B was hemorrhaging and in need of an emergent hysterectomy. At 2:55 p.m., Physician 1, assisted by Physician 2 while Dr. Anglero observed, began a hysterectomy, which ended at 5:35 pm.

v. On completion of the hysterectomy, Physician 2 left the OR. At 5:42 p.m., Dr. Anglero ordered Patient B returned to the lithotomy position so that she could determine what vaginal bleeding was occurring. Dr. Anglero removed the patient's vaginal packing, but was again unable to suture the friable vaginal mucosa. Physician 1, concerned that the patient was "likely

going into disseminated intravascular coagulation,” stopped the surgery at 7:22 p.m., and Patient B’s vagina was packed. Patient B was transported to the PACU/ICU with a central line and was bagged by a CRNA until a respiratory therapist placed her on a ventilator.

vi. Physician 1 estimated that Patient B lost 4500cc of blood following the delivery. Intraoperatively, Patient B received a massive transfusion, to include:

- 8 units of packed red blood cells;
- 4 units of fresh, frozen plasma;
- 1 donor unit of platelets;
- 1 unit of cryoprecipitate;
- 1,000 mg Cytotec;
- 750 ml albumin; and
- 6,300 ml intravenous fluid.

vii. On December 12, 2012, Dr. Anglero informed Physician 1 that she wanted to take Patient B back to the OR to re-attempt repair of the vaginal lacerations, approximately 24 hours after completing the hysterectomy. Physician 1 advised against this and further informed Dr. Anglero that she consulted a gynecologic oncologist who recommended a scan with an injection of a radioisotope to locate the etiology of the continued bleeding. Physician 1 stated to the DHP investigator that she assumed she would be included in this next surgical attempt.

viii. The following day, Dr. Anglero returned Patient B to the OR, again unpacked the patient’s vagina and again attempted to suture the lacerations. Dr. Anglero did so without the assistance of Physician 1 or any other physician. After a 38-minute unsuccessful attempt to suture the lacerations, Dr. Anglero re-packed Patient B’s vagina and returned Patient B to the ICU. On learning of this incident, Physician 1 instructed Dr. Anglero that she was “not to touch [the] patient again.” Physician 1 scheduled another exam for Patient B, under anesthesia, for December 15, 2012.

ix. On December 15, 2012, Dr. Anglero, Physician 1 and a more experienced OB/GYN (“Physician 3”) entered the OR for a third attempt at repairing Patient B’s

vaginal lacerations under anesthesia. This operation included vaginal cuff repair, repair of a 2 centimeter deep left sulcal laceration, and multiple 1 centimeter bilateral vaginal wall lacerations. Dr. Anglero again unsuccessfully attempted to repair the lacerations. Physician 3 took over the surgery and sutured Patient B as Dr. Anglero and Physician 1 exposed the area for him. Patient B was discharged on December 19, 2012.

x. Dr. Anglero testified before the Board regarding Patient B. She testified that the fetal head was at plus 1 or plus 2 station, not 0 station as noted by the nursing staff at the hospital, the medical record, and Physician 2. Dr. Anglero, in testimony, could not recall the position the baby's head was in prior to placing the vacuum, yet insisted she knew the head station and that that station was not what was reflected in the record. The Board did not find this testimony credible.

b. On multiple occasions in 2013, Dr. Anglero failed to timely respond to pages and calls from hospital staff regarding patients' care and treatment while she was the on-call physician for Patients C-F, as detailed in Paragraph 3.

c. From July 2 to September 30, 2014, Dr. Anglero failed to adequately assess, evaluate and treat Patient A for incompetent cervix and premature labor, resulting in fetal demise.

i. Dr. Anglero documented and discussed with Patient A her prior history of incompetent cervix with a premature, second trimester delivery of a stillborn infant on December 7, 2013 at approximately 20 weeks' gestation. This discussion and documentation was contemporaneous with and after diagnosing Patient A's subsequent pregnancy on July 2, 2014. Despite this documentation, discussion, and awareness of Patient A's history, Dr. Anglero failed to provide appropriate care to Patient A.

- Dr. Anglero failed to request, obtain, and review Patient A's prior pregnancy, labor, and delivery records.

- Dr. Anglero failed to develop or record an active problem list or treatment plan for Patient A at any time during the treatment period.
- Dr. Anglero failed to monitor Patient A's cervical length at appropriate two-week intervals.
- Dr. Anglero failed to timely place a prophylactic cervical cerclage at 11-15 weeks' gestation in Patient A, despite the patient's persistent, documented complaints at multiple "problem" office and hospital visits of ongoing signs and symptoms of cervical incompetency. These complaints included feelings of pelvic pressure, low backache, and increased vaginal discharge, which Patient A described as "the same" symptoms she experienced with her prior pregnancy loss.
- Dr. Anglero failed to order and administer 17-hydroxyprogesterone for Patient A beginning at 16 weeks' gestation.

ii. In the absence of appropriate monitoring and prophylactic treatment, on September 12, 2013, Patient A presented to the hospital at approximately 19 weeks' gestation with cervical shortening and funneling, and bulging fetal membranes. The next day, Dr. Anglero placed an emergency McDonald cerclage in Patient A's cervix.

iii. On September 30, 2014, at approximately 21 weeks' gestation, Patient A went into labor. Dr. Anglero referred Patient A to maternal fetal medicine at a Norfolk hospital, where Patient A was admitted with a diagnosis of incompetent cervix. On October 4, 2014, Patient A delivered a non-viable male infant in transverse presentation.

d. From August 1, 2012 to July 2015, Dr. Anglero failed to properly manage or maintain timely, accurate, legible and complete patient records, and required supervised recordkeeping.

- During her office practice, Dr. Anglero's treatment records were co-signed by a senior practice physician to ensure that she was appropriately documenting and recording patient care.
- On February 12, 2013, Dr. Anglero dictated the discharge summary regarding Patient B's December 2012 hospital course, which she authenticated on February 16, 2013. Of note, Dr. Anglero indicated in the discharge diagnoses "normal spontaneous vaginal delivery" and failed to note that the delivery was vacuum-assisted.

- From October 2013 to September 2014, Dr. Anglero’s hospital privileges were suspended on three occasions for failing to timely complete patient records. The first two suspensions were for one week and the third suspension was for two weeks.
- On or about September 13, 2014, Dr. Anglero completed a McDonald rescue cerclage on Patient A, as detailed above, yet she did not submit her operative report for this procedure until October 5, 2014 (22 days later). Dr. Anglero indicated in deposition testimony that she dictated the operative report on October 5, 2014 from memory.
- Subsequent to resigning from practice at the Chesapeake OB/GYN office on April 1, 2015, Dr. Anglero maintained remote computer access to the practice electronic medical record (“EMR”) at her home through at least July 2015. The purpose of maintaining this remote access was to bring delinquent patient treatment records up-to-date.

e. On four occasions from August 2013 to June 2015, the Medical Executive Committee (“MEC”) of the Chesapeake, Virginia hospital at which Dr. Anglero had privileges placed her on corrective action plans, which included practice restrictions, based on the following conduct.

- On August 22, 2013, the MEC initiated corrective action on Dr. Anglero based on its “concern” about her “surgical management of [Patient B]” in December 2012, detailed in Paragraph 2(a). The corrective action plan mandated that she complete a focused, on-site continuing medical education (“CME”) course in obstetric emergencies and that she undergo proctoring by another physician while performing future vacuum-assisted deliveries. Physician 1 testified in a deposition that, due to the corrective action, she directed Dr. Anglero to perform Cesarean sections (“C-sections”) instead of vacuum-assisted vaginal deliveries for patients who had some failure to descend during labor.
- In March 2014, the hospital MEC recommended a second corrective action based on four patient records, dating from January 24 to December 8, 2013, documenting Dr. Anglero’s delayed responses to multiple hospital calls regarding patient care and treatment, as detailed in Paragraph 3(a). Pursuant to this recommendation, the hospital thereafter monitored Dr. Anglero’s call response times for twelve months.
- By Dr. Anglero’s own admission, in mid-to-late 2014, the MEC imposed a third corrective action on her after she revised a circumcision on hospital premises that she had previously performed on an infant. At the time, neither the mother nor the infant were hospital patients. Dr. Anglero stated that the corrective

action required her to complete a CME course on medical ethics and patient consent.

- By Dr. Anglero's own admission, in June 2015, the MEC imposed a fourth corrective action on her, regarding a patient incident that occurred in or about February-March 2015 involving shoulder dystocia with fetal demise. Dr. Anglero stated that this corrective action required proctoring of all of her obstetric deliveries for a period of six months. She further stated that she did not complete the mandated proctoring because she had ceased treating patients in Virginia as of April 2015, when she resigned from the Chesapeake OB/GYN practice.
- In August 2015, Dr. Anglero informed a North Carolina Medical Board ("NCMB") investigator that the MEC, in developing the hospital corrective action plan requiring proctoring of all of her obstetric deliveries as detailed above, also included as the basis for this action her care and treatment of another patient, who in or about March 2015 developed an abscess after Dr. Anglero performed a C-section on the patient.

f. By her own admission, in 2017 Dr. Anglero agreed to voluntarily inactivate her North Carolina medical license in response to the NCMB's requirement that she perform a skills assessment in order to maintain her license in that jurisdiction, citing financial inability to comply with this requirement.

3. In her care and treatment of patients from August 2012 to April 2015, Dr. Anglero engaged in a pattern of unprofessional and disruptive conduct in health care settings that interfered with patient care, or could reasonably be expected to adversely impact the quality of care rendered to patients.

a. On four occasions from January 24 to December 8, 2013, Dr. Anglero failed to timely or adequately respond to hospital calls regarding Patients C – F.

i. Patient C was treated by another physician in Dr. Anglero's practice for fetal growth restriction and pre-term labor, which included fetal monitoring and Celestone (C-VI) injections on January 17 and 18, 2013.

- On January 24, 2013 at 7:58 a.m., the patient arrived at the hospital for an outpatient fetal non-stress test.
- From 8:37 to 9:00 a.m., hospital staff paged Dr. Anglero on three occasions, but she failed to answer these pages.
- At 9:08 a.m., hospital staff called Dr. Anglero at her practice office, but she failed to answer.
- At 9:13 a.m., another physician at Dr. Anglero's practice ordered Patient C's discharge after reviewing the hospital report.

ii. Patient D reported to the hospital labor and delivery department on January 24, 2013 at 3:13 p.m. in labor. Patient D stated that she was at 3 centimeters dilation earlier that day in the office, and that she was experiencing reddish-brown discharge with increasing contractions since that visit, at which her membranes were stripped.

- Dr. Anglero failed to respond to a message left by hospital staff on her cell phone at 3:32 p.m.
- At 3:48 p.m., hospital staff called Dr. Anglero's practice and office staff indicated that she had not returned office phone calls.
- At 4:09 p.m., Dr. Anglero called the unit and received report, instructing hospital staff to recheck the patient one hour from the original exam.  
At 4:38 p.m., hospital staff reported the result of the patient's sterile vaginal exam to Dr. Anglero, and she issued an order.
- At 5:47 p.m. and 6:10 p.m., staff called Dr. Anglero's cell phone and left messages for her to return call for a report on the patient.
- At 6:35 p.m., Dr. Anglero called the labor and delivery unit and received the patient report.

iii. Dr. Anglero failed to respond to contact attempts from the hospital regarding Patient E.

- At 9:10 a.m. on October 13, 2013, Patient E presented to the hospital labor and delivery unit in active labor at 7-8 centimeters dilation, 90% effaced and -2 station, reporting contractions since 4:00 that morning.

- At 9:23 a.m., the labor and delivery nurse left a message on Dr. Anglero's cell phone.
- At 9:27 a.m., the nurse paged Dr. Anglero.
- At 9:33 a.m., staff left a message for Dr. Anglero at her home telephone number.
- At 9:45 a.m., staff left another message for Dr. Anglero on her cell phone.
- At 9:47 – 9:48 a.m., the nurse called the OB/GYN hospitalist to request standby, as the patient was experiencing early decelerations, and called another physician at Dr. Anglero's practice, Physician 1, informing Physician 1 that hospital staff was unable to reach Dr. Anglero.
- At 10:10 a.m., Patient E complained of increased pressure, with the nurse noting the patient was 100% effaced at zero station.
- At 10:12 a.m., the nurse called Dr. Anglero and left another message on her cell phone.
- At 10:13 a.m., the nurse paged Dr. Anglero and called her home phone, with no answer.
- At 10:20 a.m., staff paged and called Dr. Anglero at home, with no answer. At this time, the OB/GYN hospitalist arrived at Patient E's bedside and the patient was complete.
- At 10:23 a.m., Physician 1 was at Patient E's bedside. She performed AROM, which revealed thick, pea green meconium. Consequently, she requested PEDs for delivery.
- At 10:43 a.m., Patient E delivered.

iv. Dr. Anglero failed to timely respond to contact attempts from the hospital regarding Patient F.

- On December 8, 2013, Patient F arrived at the hospital labor and delivery unit in pre-term labor.
- At 4:36 p.m., the patient was placed on observation.

- At 5:00 p.m., staff left a phone message for Dr. Anglero to call the unit for report.
- At 5:49 p.m., staff paged and called Dr. Anglero, leaving her a message to call the labor and delivery unit.
- At 5:53 p.m., staff called Dr. Anglero again.
- At 5:59 p.m., Dr. Anglero called in and staff gave her the patient's report.
- At 6:40 p.m., staff contacted Dr. Anglero regarding the patient's status. At this time, Dr. Anglero stated that Patient F was to be transferred to a Norfolk, Virginia hospital for treatment. Dr. Anglero further stated that she had not yet heard back from the on-call physician at that hospital, but that she would continue attempts to contact him.
- At 6:47 p.m., Dr. Anglero contacted staff, indicating that a physician at the Norfolk hospital would accept the patient transfer.
- At 7:40 p.m., without being seen or examined at any time by Dr. Anglero, Patient F was transferred to the Norfolk hospital via EMR.

b. Physician 1 stated in sworn deposition testimony that, during the course of Dr. Anglero's employment at her practice, she issued Dr. Anglero multiple warnings and engaged in numerous discussions with Dr. Anglero about her unprofessional conduct, which impacted or could have impacted patient care, which included the following.

- Dr. Anglero generally failed to answer her pager or hospital calls or acknowledge texts from the practice. Physician 1 cited a specific incident in which another practice physician was required to treat Dr. Anglero's patient regarding a poor fetal tracing after the hospital and practice tried, unsuccessfully, to reach Dr. Anglero.
- Dr. Anglero failed to provide obstetric patients with information that they wanted, such as lab results.
- Physician 1 heard concerns from another practice physician and a physician assistant regarding Dr. Anglero's lack of professional courtesy, which included Dr. Anglero's repetitive tardiness, failure to round as a "team player," and failure to contact colleagues prior to arriving late to the office.

- Dr. Anglero notified the practice on December 21, 2013 that she was unavailable to take call on that same day because she was in North Carolina dealing with an arrest warrant for driving on a suspended license and failure to pay administrative fees.
  - Dr. Anglero failed to regularly attend Wednesday morning practice meetings.
- c. In sworn deposition testimony, Dr. Anglero stated the following.
- On March 26, 2014, her employer, Physician 1, texted Dr. Anglero to ask her whereabouts and she informed Physician 1 that she was in court due to a rescheduled court date.
  - On two occasions at her practice office, Dr. Anglero received personal telephone calls while treating a patient or performing procedure, identified the caller to the patient, and left the room to answer the call. Dr. Anglero received a warning from Physician 1 for this behavior pursuant to a patient's complaint.

4. Dr. Anglero materially misrepresented facts and provided fraudulent, false, and misleading information in her Application for Licensure to Practice Medicine and Surgery in Virginia and her application for medical licensure in North Carolina; in her applications for employment and hospital privileges; and on her Virginia Board of Medicine Practitioner Profile.

a. In her October 27, 2011 Virginia Application for a License to Practice Medicine and Surgery in Virginia ("Application"), Dr. Anglero answered two questions falsely.

i. Dr. Anglero answered "No" to the question on the Application that asked, "Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence)," despite the fact that she was convicted of misdemeanor petit larceny in New York State on August 27, 1992. New York State criminal history information indicates that Dr. Anglero was originally charged with Grand Larceny – Fourth Degree, and that as the result of her guilty plea to a misdemeanor, she was sentenced to three (3) years' probation and fined \$5,321.00.

ii. Dr. Anglero answered “No” to the question on the Application that asked, “Have you ever been...censured or warned, or requested to withdraw from the staff of any medical school, residency or fellowship training, hospital, nursing home, or other health care facility, or health care provider?” despite the fact that during her OB/GYN residency training program at a New York hospital from June 23, 2008 to July 4, 2012, she was placed on academic and professional probation for three months, during which time she was removed from her administrative chief duties. According to the Director of the OB/GYN residency program, the hospital’s gynecologic oncologist filed a negative report regarding Dr. Anglero’s conduct, expressing concerns about her failure to meet the basic requirements expected of a resident on his service, citing her “poor performance, lateness, and a need to demonstrate better accountability.”

b. By her own admission in sworn deposition testimony in 2012, Dr. Anglero failed to disclose the prior New York State petit larceny conviction in her application for privileges at a Norfolk, Virginia hospital. After discovering this omission, the hospital did not grant Dr. Anglero privileges.

c. Dr. Anglero failed to disclose this prior petit larceny charge to her former employer prior to her hiring in August 2012.

d. Dr. Anglero falsely reported on her Virginia Board of Medicine Practitioner Profile that she is board-certified in obstetrics and gynecology.

e. In her January 2015 NCMB Physician Application, which was acknowledged under oath by Dr. Anglero as correct on March 9, 2015, Dr. Anglero answered falsely or failed to answer multiple questions.

i. In response to the question on the NCMB Application that asked, “Are you aware of any complaint or investigation or inquiry, ever, regarding you that has been received or

conducted by any of the following: professional licensing board or agency...hospital or other healthcare organization,” Dr. Anglero answered, “Failed to respond in the 20 min allotted time after a page on 3 occasions in a 12 month period,” despite the fact that at the time, she was also aware of the complaints received by and the investigations conducted by the Chesapeake, Virginia hospital and the Virginia Board of Medicine regarding her care and treatment of Patients B – F, as detailed in Paragraphs 2 and 3.

ii. In response to the question on the NCMB Application that asked, “Have you ever had an action taken against you by a health care institution, including employers or group practices? If so, list each occurrence...Actions include...Warnings, Censures, Discipline...Privileges limited, suspended or revoked...Probation...Health care institutions include: Hospitals...Any facility in which you were trained...Any group practice...,” Dr. Anglero answered only that on October 1, 2014, she was suspended by the Chesapeake, Virginia hospital for “Incomplete charting.” With this answer Dr. Anglero failed to disclose the four corrective action plans and additional suspensions imposed on her by this hospital, as detailed in Paragraph 2. Further, Dr. Anglero failed to disclose the multiple discussions with and warnings administered by her prior employer regarding her unprofessional conduct, as detailed in Paragraph 3, and that she was placed on probation during her OB/GYN residency, as detailed above.

iii. In answer to the question on the NCMB Application that asked, “While at any professional school, or training program, have you ever: been suspended, placed on scholastic or disciplinary probation, expelled or asked to resign...?,” Dr. Anglero answered, “[S]uspended for one day during residency due to incomplete charting,” despite the fact that during residency she was placed on academic and professional probation for three months, during which time she was removed from her chief administrative duties, as detailed above.

iv. Dr. Anglero failed to answer the question on the NCMB Application that asked, “Have you ever had an action taken against you by a regulatory board or agency? If so, list each occurrence... Actions include, but are not limited to: Private actions and letters...[and] Regulatory board or agency includes: Any professional licensing board or agency,” despite the fact that she received, in April 2014 and January 2015, advisory letters from the Virginia Board of Medicine regarding her care and treatment of Patient B as detailed in Paragraph 2 and regarding missed or delayed responses to hospital calls regarding Patients C – F, as detailed in Paragraph 3.

5. In her testimony before the Board, Dr. Anglero stated that she has not practiced medicine since 2016.

### **CONCLUSIONS OF LAW**

1. Finding of Fact No. 2 constitutes a violation of Virginia Code § 54.1-2915(A)(3), (4), (13), and (18) and 18 VAC 85-20-26(C) of the Regulations Governing the Practice of Medicine, Osteopathy, Podiatry and Chiropractic (“Regulations”).

2. Finding of Fact No. 3 constitutes a violation of Virginia Code § 54.1-2915(A)(12) (13), (16) and (18) and 18 VAC 85-20-29(A)(2) of the Regulations.

3. Finding of Fact. No. 4 constitutes a violation of Virginia Code § 54.1-2915(A)(1), (16) and (18), and 54.1-111(A)(6).

### **ORDER**

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS as follows:

1. The right of Melissa Anglero, D.O., to renew her license to practice osteopathy and surgery in the Commonwealth of Virginia is REVOKED.

2. The license of Dr. Anglero will be recorded as REVOKED.

3. Pursuant to Virginia Code § 54.1-2408.2, should Dr. Anglero seek reinstatement of her license after three years, the reinstatement of Dr. Anglero’s license shall require the affirmative vote of three-fourths of the members at a formal administrative proceeding convened by the Board. At such time, the burden shall be on Dr. Anglero to demonstrate that he is safe and competent to return to the practice of medicine and surgery. Dr. Anglero shall be responsible for any fees that may be required for the reinstatement and/or renewal of the license prior to issuance of the license to resume practice.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

**FOR THE BOARD**

*FOR*  
  
\_\_\_\_\_  
**William L. Harp, M.D.**  
**Executive Director**  
**Virginia Board of Medicine**

**ENTERED** 6/25/2019

**NOTICE OF RIGHT TO APPEAL**

As provided by Rule 2A:2 of the Supreme Court of Virginia, you have 30 days from the date you are served with this Order in which to appeal this decision by filing a Notice of Appeal with William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

**Vision:** To be the **Healthiest State** in the Nation

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July 29, 2019

**CONFIDENTIAL**

Dr. Melissa Nmn Anglero  
400 Ne 137th Street, Apt 211  
North Miami, FL 33161

Complaint #: 201932857

Dear Dr. Anglero:

The Consumer Services Unit received the enclosed complaint. We have determined you may have violated the practice act regulating your profession. Therefore, we have opened an investigation. Please submit a written response within 45 days of receipt of this letter. Please include the complaint number 201932857 on any correspondence you provide to our office.

You may make a written request for a copy of the investigative file. This complaint and all investigative information will remain confidential until 10 days after the probable cause panel has determined a violation has occurred or you give up the right to confidentiality.

Sincerely,

Antoinette F. Carter  
Government Analyst I

Enclosure  
DOH-Form300

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**Florida Department of Health**

Division of Medical Quality Assurance • Bureau of Enforcement  
4052 Bald Cypress Way, Bin C-75 • Tallahassee, FL 32399-3275  
PHONE: (850) 245-4339 • FAX : (850) 488-0796



**Accredited Health Department**  
Public Health Accreditation Board

Exhibit #2  
Page #026

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Ron DeSantis**  
Governor

**Scott A. Rivkees, M.D.**  
State Surgeon General

**Vision:** To be the Healthiest State in the Nation

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**MEMORANDUM FOR RECONSIDERATION**

**TO:** Probable Cause Panel

**FROM:** Corynn Alberto, Assistant General Counsel

**RESPONDENT:** James Scott McAdoo, D.O.

**DOH Case Number:** 2016-25271

**DATE:** August 31, 2020



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On January 15, 2020, this case was presented to the Probable Cause Panel. Thereafter, a two-count administrative complaint was filed alleging that Subject violated section 459.015(1)(x), Florida Statutes, by committing medical malpractice, or in the alternative, section 459.015(1)(o), by failing to create/maintain adequate medical records.

Following the filing of the Administrative Complaint, Subject's attorney provided additional information, including medical records, to the Department for review. The Department provided those documents to its expert. In an addendum opinion, the expert found that based on the new information provided, she could no longer support a violation of the standard of care.

Based on the foregoing, the Department can no longer support the charges in its Administrative Complaint and requests that the Panel reconsider its finding of probable cause and dismiss this case.

STATE OF FLORIDA  
DEPARTMENT OF HEALTH

BOARD: Osteopathic Medicine

CASE NUMBER: 2016-25271

COMPLAINT MADE BY: DOH/CSU-Media Analyst

COMPLAINT MADE AGAINST: James Scott McAdoo, D.O.  
1616 Sandpiper Circle  
Weston, FL 33327

REPRESENTED BY: Ryan Sanders, Esquire  
Museum Plaza, Suite 900  
200 South Andrews Avenue  
Ft. Lauderdale, FL 33301

DATE OF COMPLAINT: October 5, 2016

INVESTIGATED BY: George Mulero, MQA Investigator  
Miami ISU

REVIEWED BY: Corynn Alberto  
Assistant General Counsel

RECOMMENDATION: Dismiss 4099

CA

**NOTICE OF DISMISSAL/CLOSING ORDER RECONSIDERATION**

THE COMPLAINT: The complaint alleges that Respondent violated section 459.015(1)(o), Florida Statutes, by failing to keep legible medical records and section 459.015(1)(x), Florida Statutes, by committing medical malpractice.

THE FACTS: This case was predicated upon receipt of a Case Summary and initiating documents related to a news article from www.telemundo51.com. The article alleged that Subject performed plastic

surgery on a patient, who later was found to have necrotic tissue, requiring skin grafts and 24-hour wound care.

On April 26, 2016, Patient IB (IB), a then 45-year-old female, presented to Subject at Encore Plastic Surgery for a mastopexy, abdominoplasty, and flank suction-assisted lipectomy. IB tolerated the procedure, without complication, and was transferred to recovery in stable condition. Three weeks after the procedure, IB presented to Jackson Memorial Hospital for emergency surgery requiring debridement of necrotic tissue, wound VAC, and skin graft.

An expert for the Department reviewed this case and found that Subject failed to keep adequate medical records and violated the standard of care in his treatment of IB.

On January 15, 2020, this case was presented to the Probable Cause Panel. Thereafter, a two-count administrative complaint was filed alleging that Subject violated section 459.015(1)(x), by failing to obtain a complete and comprehensive physical exam, failing to obtain a complete medical history, and/or by failing to see or contact the patient within 24-48 hours postoperatively, or in the alternative, section 459.015(1)(o), by failing to create/maintain records of obtaining a complete medical history, failing to create/maintain a record of performing a complete and comprehensive physical exam, and/or by failing to create/maintain a record of contacting the patient within 24-48 hours.

Following the filing of the Administrative Complaint, Subject's attorney provided additional information, including medical records, to the Department for review. The Department provided those documents to its expert. In an addendum opinion, the expert found that based on the new information provided, she could no longer support a violation of the standard of care.

In light of the fact that the expert has changed her opinion and no longer believes a violation exists, the Department recommend that the Panel reconsider its finding of probable cause and dismiss the case.

THE LAW: Therefore, pursuant to section 456.073(2), Florida Statutes, the case is hereby DISMISSED.

It is, therefore ORDERED that this matter be, and same is hereby, dismissed.

DONE AND ORDERED this 30<sup>th</sup> day of October 2020.

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Chairperson, Probable Cause Panel  
Board of Osteopathic Medicine

PCP Date: October 30, 2020

PCP Members:

Patricia Rooney, D.O., F.A.C.O.S.

1880 E. Commercial Blvd, Suite 1  
Fort Lauderdale, FL 33308

April 1, 2020

FL Department of Health, PSU  
4052 Bald Cypress Way Bin C-65  
Tallahassee, Florida 32399-3265

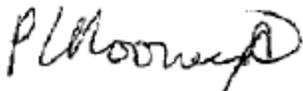
Regarding: DOH v JM 2016-25271

Dear Department of Health, PSU,

I have reviewed the additional medical records. The records coincidentally address the issues and support that the Subject did meet the standard of care.

If you have any further questions, please call (407) 766-0882 to schedule a telephone conference.

Sincerely,

A handwritten signature in black ink, appearing to read "P. Rooney". The signature is written in a cursive, somewhat stylized font.

Patricia Rooney, D.O., F.A.C.O.S.

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**STATE OF FLORIDA  
DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**PETITIONER,**

**v.**

**CASE NO. 2016-25271**

**JAMES S. MCADOO, D.O.,**

**RESPONDENT.**

\_\_\_\_\_ /

**ADMINISTRATIVE COMPLAINT**

COMES NOW Petitioner, Department of Health, by and through its undersigned counsel, and files this Complaint before the Board of Osteopathic Medicine against Respondent, James S. McAdoo, D.O., and in support thereof alleges:

1. Petitioner is the state agency charged with regulating the practice of osteopathic medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 459, Florida Statutes.
2. At all times material to this Complaint, Respondent was a licensed osteopathic physician within the State of Florida, having been issued license number OS 11955.

3. Respondent's address of record is 1616 Sandpiper Circle, Weston, Florida 33327.

4. Respondent may be located at 1738 West 49<sup>th</sup> Street, Suite 8, 9, 10, Hialeah, Florida 33012.

5. At all times material to this Administrative Complaint, Respondent was practicing as an osteopathic physician at Encore Plastic Surgery (Encore) located in Hialeah, Florida.

6. Respondent is board-certified by the American Osteopathic Board of Surgery in General Surgery and in Plastic Surgery.

7. On or about April 22, 2016, Patient I.B., a then-forty-five-year-old female, presented to Respondent at Encore for a "Mommy Makeover" plastic surgery procedure (the procedure) consultation. This procedure involves mastopexy, abdominoplasty, and flank suction assisted lipectomy.

8. The prevailing professional standard of care required Respondent to obtain a complete and comprehensive patient history from Patient I.B. prior to performing the procedure.

9. The prevailing professional standard of care required Respondent to perform a complete and comprehensive physical examination of Patient I.B. prior to performing the procedure.

10. Respondent did not obtain, or did not create and maintain a record of obtaining, a complete medical history for Patient I.B.

11. Respondent did not perform, or did not create and maintain a record of performing, a complete and comprehensive physical examination of Patient I.B.

12. On or about April 26, 2016, Patient I.B. presented to Encore to undergo the procedure.

13. The op note for the procedure indicates that Patient I.B. tolerated the procedure without complication and was transported to the recovery area in stable condition.

14. The standard of care required that Patient I.B. be seen or contacted within 24-48 hours post operatively.

15. Respondent failed to see, or did not create and maintain a record of seeing, Patient I.B. for a post-op visit within 24-48 hours after the procedure.

16. Respondent failed to contact, or did not create and maintain a record of contacting, Patient I.B. 24-48 hours post-operatively.

17. Three weeks after the procedure, Patient I.B. presented to Jackson Memorial Hospital for emergency surgery requiring debridement of necrotic tissue, wound VAC and skin graft.

**COUNT ONE**

18. Petitioner re-alleges and incorporates paragraphs one (1) through sixteen (16), as if fully set forth herein.

19. Section 459.015(1)(x), Florida Statutes (2015), provides that, notwithstanding s. 456.072(2) but as specified in s. 456.50(2), committing medical malpractice as defined in s. 456.50, F.S., constitutes grounds for disciplinary action. Medical Malpractice is defined in Section 456.50(g), Florida Statutes (2015), as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. For purposes of Section 459.015(1)(x), Florida Statutes (2015), the Board shall give great weight to the provisions of Section 766.102, Florida Statutes (2015), which provide that the prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

20. As set forth above, Respondent committed medical malpractice by falling below the prevailing professional standard of care in his treatment of Patient I.B. in one or more of the following ways:

- a. By failing to obtain a complete and comprehensive physical examination of Patient I.B.;
- b. By failing to obtain a complete medical history for Patient I.B.; and/or
- c. By failing to see or contact Patient I.B. within 24-48 hours post-operatively.

21. Based on the foregoing, Respondent violated Section 459.015(1)(x), Florida Statutes (2015), in his treatment of Patient I.B. by committing medical malpractice, as defined in Section 456.50(g), Florida Statutes (2015), as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

### **COUNT TWO**

22. Petitioner re-alleges and incorporates paragraphs one (1) through sixteen (16), as if fully set forth herein.

23. Section 459.015(1)(o), Florida Statutes (2015), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed osteopathic physician or the osteopathic physician extender and supervising osteopathic physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

24. In the alternative to Count I, Respondent failed to keep adequate medical records in one or more of the following ways:

- a. By failing to create and maintain a record of obtaining a complete medical history for I.B.;
- b. By failing to create and maintain a record of performing a complete and comprehensive physical examination of Patient I.B.; and/or
- c. By failing to create and maintain a record of contacting or seeing Patient I.B. within 24-48 hours of the procedure.

25. Based on the foregoing, Respondent violated Section 459.015(1)(o), Florida Statutes, (2015), by failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed osteopathic physician [who is] responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient.

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

*(Signature appears on following page)*

SIGNED this 15<sup>th</sup> day of January, 2020.

Scott A. Rivkees, M.D.  
State Surgeon General

*Corynn Alberto*

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Corynn Alberto  
Assistant General Counsel  
DOH Prosecution Services Unit  
4052 Bald Cypress Way, Bin C-65  
Tallahassee, FL 32399-3265  
Florida Bar # 0068814  
(850) 558-9843 Telephone  
(850) 245-4640 Facsimile

**FILED**

DEPARTMENT OF HEALTH  
DEPUTY CLERK

CLERK: *Annelle Morris*  
DATE: JAN 15 2020

PCP: January 15, 2020

PCP Members: Glenn Moran, D.O. and Anna Hayden, D.O.

## **NOTICE OF RIGHTS**

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

**A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.**

**Mediation under Section 120.573, Florida Statutes, is not available to resolve this Administrative Complaint.**

## **NOTICE REGARDING ASSESSMENT OF COSTS**

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

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To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Rick Scott**  
Governor

**Celeste Philip, MD, MPH**  
Interim State Surgeon General

**Vision:** To be the **Healthiest State** in the Nation

12/05/2016

**CONFIDENTIAL TO:**

James Scott McAdoo  
1850 South Ocean Drive  
Hallandale, Florida 33009

Case Number: 2016-25271

Dear Dr. McAdoo:

We are currently investigating a case received by the Department of Health. The allegation, if substantiated, would be a violation of SS ss. 459.015(1)(g)(o)(x)(pp), 456.072(1)(k)(dd), F.S. and Rule 64B15-15.004, F.A.C

Within **45 days** of receiving this letter, you may:

- \* submit a **written response** to the address below; or
- \* call our office to schedule an **interview**.

Please provide a copy of your **resume** and identify the **address of your current employer**, even if you chose not to submit a response. This information, your response (if one is provided) and any other information gathered during the investigation will be considered by the Probable Cause Panel when determining whether a formal administrative complaint should be filed in this matter. Include the above-referenced case number in any correspondence you send.

Florida law requires that this case and all investigative information remain confidential until 10 days after the panel has determined that a violation occurred or you give up the right to confidentiality. Therefore, the contents of the investigation cannot be disclosed to you or the general public.

You are not required to answer any questions or give any statement, and you have the right to be represented by an attorney. It is not possible to estimate how long it will take to complete this investigation because the circumstances of each investigation differ.

The mission of the Department of Health is to protect, promote & improve the health of all people in Florida through integrated state, county and community efforts. If you have any questions, please call us at 305-470-5894.

Sincerely,

George Mulero, CFE  
Medical Malpractice Investigator

**Florida Department of Health**  
**Division of Quality Assurance Bureau of**  
**Enforcement**

8350 NW 52<sup>nd</sup> Terrace # 400 Doral, Florida 33166  
PHONE: 305-470-5894 Fax-305-499-2090

**FloridaHealth.gov**



**Accredited Health Department**  
Public Health Accreditation Board

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456.057 - Ownership and control of patient records; report or copies of records to be  
furnished.—

10)(a)All patient records obtained by the department and any other documents  
maintained by the department which identify the patient by name are confidential and exempt  
from s. 119.07(1) and shall be used solely for the purpose of the department and the appropriate  
regulatory board in its investigation, prosecution, and appeal of disciplinary proceedings. The  
records shall not be available to the public as part of the record of investigation for and  
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