Adverse Actions Report January-February 2024

The digital edition of the *Forum* presents a two-month report of recent adverse actions. This report does not include non-adverse action such as reentry agreements or relief of consent order obligations. To view all public actions, visit www.ncmedboard.org/BoardActions.

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
DHAWAN, Surinder, MD (009701318) Cary, NC	1/26/2024	In October 2023, MD entered into a Consent Order with the Board in which he agreed to schedule a comprehensive examination at the first available appointment date. Despite agreeing to schedule and submit to examination, MD has refused to do so, thus violating the terms and conditions of the 2023 Consent Order. MD's refusal to submit to comprehensive examination constitutes his failure to comply with a Board Order within the meaning of N.C. Gen. Stat. § 90-14(a)(14) and also constitutes unprofessional conduct.	Order of Summary Suspension of License
IKRAMELAHAI, Sasha Melissa (001013544) Locust Grove, GA	01/29/2024	PA-1 applied for and was issued a license to practice as a physician assistant in NC. PA-1 accepted an offer of employment at a practice located in Southern Pines, NC. She purported to practice as a physician assistant in Southern Pines, though she did not treat or prescribe to any patient due to being in training at the practice. The Board received a complaint from PA-2, a practicing PA in New Mexico, alleging that PA-1 fraudulently used her academic, professional, and	Order of Summary Suspension of License

		personal information to obtain a license to practice as a PA in NC. The conduct of PA-1 as described above and as may be shown by further evidence, constitutes immoral and dishonorable conduct, constitutes making false statements or representations to the Board, or willfully concealing from the Board, material information in connection with an application for a license and constitutes unprofessional conduct.	
IKRAMELAHAI, Sasha Melissa (001013544) Lagrange, GA	02/27/2024	The Board acted to summarily suspend PA's NC license after learning that PA fraudulently used the academic, professional, and personal information of a PA licensed in New Mexico to obtain her NC PA license. PA received proper notice of the Board's Order of Summary Suspension and notice of a February 15, 2024, hearing. The Board heard the sworn testimony of witnesses. Despite proper notice, PA did not appear at the hearing, and thus, presented no evidence.	Order of summary suspension upheld; PA License remains summarily suspended effective January 29, 2024
REVOCATIONS			
STEVENS, Craig A.**,** MD (009700773)	02/27/2024	MD was convicted of three felony counts of Indecent Liberties with a Minor.	Medical license revoked retroactively, effective 11/ 01/2023
SUSPENSIONS			
BURGOA RIO, Carlos Fernando, PA-C (001002248) Winston-Salem, NC	01/29/2024	In September 2022, during a routine care visit, it is alleged that PA made inappropriate sexual comments and inappropriately touched Patient. PA denies these allegations. As a result of Patient's complaint, PA's	Indefinite suspension effective 01/25/24. Effective 01/26/25, suspension is stayed with conditions. PA shall not have any female patient encounters.

		employer terminated his employment. It was noted in his termination that the employer had received similar patient complaints of inappropriate behavior by PA in 2014 and 2021.	
LIMITATIONS/CONDITIONS			
CORRINGTON, Kip Alan, MD (200000755) Oak Ridge, NC	01/08/2024	Based on concerns related to MD's care of a patient who established care with him to continue treatment of her opioid dependence and receive general medical care, the Board obtained four additional patient records from MD and submitted them to an independent reviewing expert. The reviewing expert found that MD's care for the five patients failed to conform to the standards of acceptable and prevailing medical practice. Specifically, MD failed to provide adequate documentation, including diagnostic criteria for opioid use disorder and/or other co-morbidities; failed to perform appropriate pharmacovigilance or implement diversion control measures, including monitoring the NCCSRS, performing regular urine drug screens, or addressing aberrant urine drug screen results; had limited face-to-face visits and failed to comprehensively address ongoing problems; failed to document any discussion of dose reduction, alternate therapies, or referral to counseling.	Consent Order; Conditions placed on NC medical license
REIMERS, Charles Edward, PA-C	02/23/2024	In January 2023 Consent	Consent Order; PA shall

(0010-00829) Bar Harbor, ME		Agreement with the Maine Medical Board, PA agreed to enter into a contract with the Maine Professionals Health Program (MPHP) and successfully comply with all contract requirements for a minimum of two years. PA was also prohibited from directly supervising female co-workers and staff and required to enroll in CME courses relating to professional boundaries and disruptive behavior. In April 2023, PA entered into a contract with the North Carolina Professionals Health Program. PA is currently in compliance with his MPHP and NCPHP contracts.	not directly supervise female staff or co-workers
SMITH, Tracey, PA-C (000102582) Greenville, NC	01/30/2024	The Board received three separate but similar complaints from former employees regarding PA. They alleged that PA regularly made inappropriate comments of a sexual nature, made unwanted contact and/or sexual advances towards them, and created a hostile work environment by his constant sexual overtones. Additionally, two patients confirmed that PA made inappropriate comments and inappropriately touched or hugged them.	Suspension; Stayed with Conditions
REPRIMANDS			
DAVIS, Bradley Scott, MD (201401468) Asheville, NC	01/29/2024	MD was involved in a domestic dispute with his wife. He admits that he and his wife consumed multiple alcoholic beverages and argued and that she called 911, but he denies assaulting her. The Board ordered MD	Reprimand

		to the North Carolina Professionals Health Program for assessment. NCPHP assessed MD and determined he did not have an undiagnosed or untreated substance use disorder. NCPHP recommended MD sign a one-year monitoring contract to include counseling.	
EPSTEIN, Andrew, DO (202202776) Tucson, AZ	01/04/2024	DO is a contract provider for an online telehealth platform offering a variety of services and treatments to patients nationwide in states where he is licensed. In May 2023, the Board received a complaint from a patient regarding a telehealth appointment in which he was prescribed Ketamine by DO. The Board obtained the medical records of three other North Carolina patients who DO prescribed Ketamine to via the telemedicine platform. Patients are collectively referred to as Patients A-D. The Board's independent medical expert found that DO failed to conduct urine drug screens and failed to conduct and document thorough physical examinations and comprehensive medical histories prior to prescribing Ketamine to Patients A-D; DO failed to ensure that a clear protocol was in place for patient monitoring, follow-up visits, and assessments for side effects and adverse reactions; and DO failed to establish guidelines for prescribing, dispensing, and monitoring the use of	Reprimand; Restricted from prescribing Ketamine; DO to complete CME

		Ketamine to prevent its misuse.	
PURDY, Laura Ellen, MD (201801536) Miami, FL	02/21/2024	In May 2023, the Mississippi Medical Board placed restrictions on MD's medical license based on her failure to establish a valid physician-patient relationship by using a questionnaire in lieu of physical examination; and unprofessional conduct. The Virginia Medical Board suspended MD's medical license in July 2023 based on the Mississippi Board action. Also, in July 2023 the Tennessee Medical Board reprimanded her and assessed a civil penalty based on the Mississippi action.	Reprimand
RUNHEIM, Andreas David, MD (200401571) Winston-Salem, NC	01/03/2024	During its investigation, the Board reviewed charts of four patients for whom MD had been asked to perform new nerve conduction studies or electromyography studies. For all four patients, the Board found MD's care fell below the standards of acceptable and prevailing medical practice. Specifically, he failed to document a demonstrated medical indication for some studies, and at times, the conclusions he drew from his studies were not commensurate with the studies' findings.	Reprimand; Suspension stayed with conditions
SCHNARRS, Robert Harold, MD (000038430) Norfolk, VA	02/29/2024	The Virginia medical board reprimanded MD and required him to complete 8 hours of CME on the subject of professional boundaries. Virginia took action because MD violated professional boundaries when he	Reprimand

		terminated his physician-patient relationship with a patient in writing, in order to pursue a romantic relationship. However, after that time, MD continued to perform invasive procedures on, and prescribe medications to the patient without a bona fide physician-patient relationship.	
SPAHN, Kreig, DO (201502151) Glen Alpine, NC	02/28/2024	The Board was informed that DO was investigated by a health plan that offers managed care services to Medicaid beneficiaries, due to concerns related to his prescribing of controlled substances. Based on this information, the Board obtained five patient records from DO to be reviewed by an independent medical expert. The reviewer found that DO's care for four of the five patients failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. Specifically, DO failed to perform appropriate diagnostic evaluations, significant examinations or imaging prior to prescribing controlled substance pain medications and made limited attempts at dosage reduction or alternate/non-opioid therapies. In some cases he did not prescribe the opioid antagonist naloxone (Narcan). He concurrently prescribed opioids and benzodiazepines, despite the risks of oversedation.	Reprimand; DO required to complete minimum 16 hours CME on safe opioid prescribing
SPARKS, Kristen Lynn, MD	02/14/2024	In 2022, MD was found guilty	License issued with

(202400268) Raleigh, NC		of misdemeanor Operating While Under the Influence. She was on call at the time of her arrest. MD reported her arrest to the Alaska State Medical Board, her employer, and her credentialing body, all of whom investigated and took no formal action. She was evaluated and diagnosed with Alcohol Use Disorder – Severe. DO subsequently signed a 5-year monitoring contract with the Physician Health Committee of Alaska and submitted to residential treatment which she successfully completed and was deemed safe to practice. She applied for a North Carolina medical license and failed to disclose the investigations.	Reprimand
STELJES, Alan David, MD (201400782) Charleston, SC	01/05/2024	In a September 2023 Nevada State Board of Medical Examiners Settlement Agreement, MD was Reprimanded, fined and required to complete Continued Medical Education on culture of safety. The Nevada Board's Settlement Agreement was based on MD's failure to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to a patient and his failure to timely seek consultation with regard to a patient's medical condition.	Reprimand
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
NONE			
PUBLIC LETTERS OF CONCERN			

CHUNG, John Yohan, MD (201701890) Chattanooga, TN	02/23/ 2024	The Board is concerned that MD failed to document the extent to which he was assisted by a PA in two operative procedures performed on a patient in his practice. Specifically, MD did not notate in this patient's medical, or billing records the extent to which the PA had assisted in the excision and revision surgeries performed on the patient. This lack of documentation prompted MD to acknowledge his oversight in a formal Consent Order entered into with the Tennessee Board.	Public Letter of Concern
DRAPER, Brenda McCain, MD (000034091) City, ST	01/30/2024	In June 2023, the Board received information that MD had prescribed multiple controlled substances, including Ambien, lorazepam, and acetaminophen with codeine to an immediate family member. NC law prohibits prescribing controlled substances to immediate family members. During the Board's investigation MD admitted to prescribing controlled substances to an immediate family member on several occasions. While she provided the Board with a brief medical record, she did not document each medication prescribed to that family member in the medical record and did not have an established provider/patient relationship with that person.	Public Letter of Concern
ELFEKY, Hamed Abdelfatah, MD (202203208) Orlando, FL	02/21/2024	The Board is concerned that in October 2023, MD entered into an Agreed Order with the Kentucky medical board	Public Letter of Concern

		in which he was fined $1,000. After paying the fine, he was issued a Kentucky medical license. The Kentucky action was based on MD falsely answering “no” on his license application to the question, “Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were the subject to disciplinary proceedings by the hospital?” In fact, in November 2019, MD surrendered clinical privileges at a Viriginia hospital following concerns related to his care of two patients that he treated as a pathologist in 2019.	
FAROOQUE, Mohammad, MD (202102803) Jacksonville, FL	01/03/2024	The Board is concerned that in August 2023, the Florida Board issued a Letter of Concern, a fine, and required that MD successfully complete CME in prescribing controlled substances and risk management. Action was based on MD's prescribing inappropriate amounts of Clonazepam and Adderall based on the patient’s medical history and failing to document justification for prescribing the combination of controlled substances. Additionally, the Florida Board cited two occasions when the patient’s urine drug screens were negative for all controlled substances, indicating the patient was not taking prescribed controlled medications, and MD failed to investigate or	Public Letter of Concern

		failed to document investigating the cause of the negative UDS.	
HEIDER, Timothy Ryan, MD (200001489) Mooresville, NC	01/10/2024	The Board is concerned that while MD's diagnoses and treatment of Patient A, were within the standards of acceptable and prevailing medical practice, his medical record documentation was below standard. Specifically, following laparoscopic Roux-en-Y gastric bypass surgery, MD failed to document Patient A's vital signs in the progress note on post-operative day one. MD's care of Patient B may have failed to conform to the standards of acceptable and prevailing medical practice in NC. Patient B consented to surgery to convert a vertical sleeve gastrectomy performed years earlier to a laparoscopic Roux-en-Y gastric bypass surgery. The surgery MD performed on Patient B was a single anastomosis gastric bypass, which was performed without her written consent. MD's documentation was again below standard in Patient B's case. MD failed to document any pre-operative discussion with Patient B regarding the possibility of performing a single-anastomosis gastric bypass. The consent form provided to Patient B did not list the specific type of laparoscopic gastric bypass that was to be performed. In addition, the consent form did not contain any language about the possibility of a change in	Public Letter of Concern

		procedure from the previously discussed laparoscopic Roux-en-Y gastric bypass. Further, MD failed to detail in his operative report the change in his decision-making to switch from the consented procedure to the non-consented procedure, and his operative report was never updated to reflect the actual procedure he performed. Unfortunately, Patient B experienced post-operative complications resulting from a bowel leak. A leak test was not performed intraoperatively. If a leak test had been performed, it could have predicted the leak while Patient B was still in the operating room. Patient B subsequently died from sepsis.	
HOLDER, Kelly Lynne Pieh, DO (201501308) Siler City, NC	01/25/2024	The Board is concerned about DO's care of a 25-year-old female who had routine prenatal care with DO during her first pregnancy. Patient had maternal obesity and a family history of hypertension. DO's care of Patient may have failed to conform to the standards of acceptable and prevailing medical practice in NC. Specifically, DO failed to further evaluate Patient when she presented at 37 weeks and 5 days pregnant with a diastolic blood pressure of 92; Failed to document consideration of a c-section with fetal heart rate tracings persistently showing a Category II pattern; Failed to place fetal scalp electrodes	Public Letter of Concern

		given the difficulty in monitoring the fetal heart rate externally during Patient's induction; Failed to provide magnesium for seizure prevention; and DO's failure to provide timely documentation in Patient's record regarding Patient's induction, which was done via a late entry note.	
MATHEW, Rano Thomas, MD (009600112) Wilmington, NC	02/27/2024	During the Board's investigation of a complaint, MD admitted that he had received bioidentical hormone replacement therapy through testosterone pellet insertion performed by a PA in his practice whom he supervised. This prescribing of a Schedule III/IIIN controlled substance by a supervisee violated 21 NCAC 32S .0212. The Board had the care of two patients reviewed by an independent medical expert. The Board has concerns about the care provided to Patient A and about the medical records of Patient B. Care of both patients was predominately performed by a PA and MD was the supervising physician for this provider. MD was directed to review the Board's position statement on medical records documentation.	Public Letter of Concern; MD agrees to complete eight hours Category I CME in Hormone Replacement Therapy
MCCARTHY, Kevin Francis, MD (202101394) Eden Prairie, MN	02/21/2024	The Board had MD's care of a patient reviewed by an	Public Letter of Concern

		independent medical expert. The reviewing expert found that his care of a patient may have fallen below the standard of care in NC. Specifically, the reviewing expert opined that MD undermeasured a mass on a 2016 MRI, erroneously concluded that there was no significant change since the prior 2012 CT, and incorrectly attributed the findings to the presence of hemorrhage. The reviewer criticized MD's failure to obtain a surgical consult and possibly refer Patient to interventional radiology for consideration of image-guided biopsy at the time of the 2016 MRI. By the time of a 2019 CT and the referral for biopsy, the mass had grown significantly. Patient died from complications related to cancer in 2021.	
PALUMBO, Joseph Matthew, DO (202100125) Highland Heights, OH	02/12/2024	Based on a complaint from a North Carolina pharmacist, the Board became concerned about DO's care Patient A. The Board requested nine additional patient records to better evaluate DO's practice and had DO's care of Patients A through J reviewed by an independent medical expert. The reviewing expert believes that DO's medical record keeping practice needs improvement. Specifically, DO's medical	Public Letter of Concern

		records should more clearly document his patient encounters. The Board acknowledges and appreciates that DO has indicated he will take proactive steps to make such improvements.	
RAMPP, Nadine Gates, MD (202100643) Murfreesboro, TN	01/02/2024	The Board is concerned about MD's care of a 51-year-old female on whom MD performed a laparoscopic appendectomy. Pathology confirmed acute suppurative appendicitis and that MD removed a length of 2.3 cm of Patient's appendix. Approximately 4 ½ months later, Patient was found to have inflammation of remnant appendix tissue due to incomplete removal of the appendix. Patient underwent laparoscopic surgery to remove the remaining appendix. The Board's reviewing expert opined that the appendectomy was most likely incomplete and most likely due to MD's failure to adequately expose the entire appendix and identify the appendicocecal junction. The reviewing expert opined that Patient was at risk for an incomplete appendectomy due to the small amount of tissue removed during the surgery when compared to the typical length of an appendix. As a result, Patient was also at a greater risk for subsequent stump appendicitis, which is a known risk of a laparoscopic appendectomy.	Public Letter of Concern
SCHULTZ, John Frank, MD (202400186) Denver, CO	02/05/2024	The Board is concerned that MD received two Letters of	Public Letter of Concern

		Admonition from the Colorado Medical Board. In 2014 the Colorado Board had concerns that MD may have failed to promptly order a repeat head CT scan in a high risk, anticoagulated patient and reexamine the patient after there was a change in her mental status. The 2022 Letter of Admonition involved a misdemeanor conviction in 2020 for second-degree criminal tampering.	
SCHWARZ, Karl William, MD (200400591) Miami, FL	02/26/2024	The Board is concerned that the Florida Board issued a Letter of Concern, imposed an administrative fine and required MD to complete additional continuing medical education on medical recordkeeping and risk management. The Florida action was in response to allegations that during a cell saver procedure following liposuction, MD injected blood into a patient that had been contaminated with plastic beads and/or foreign bodies discovered during the liposuction procedure. The Florida Board found that by injecting contaminated blood into a patient, MD practiced below the standard of care in violation of Florida statutes and regulatory requirements. In addition, the Florida Board found MD failed to create and/or maintain adequate medical records to justify the course of treatment and satisfy statutory and regulatory requirements.	Public Letter of Concern
STOVROFF, Mark Cooper, MD (202201779) Atlanta, GA	01/02/2024	The Board is concerned that MD's care of a 13-year-old	Public Letter of Concern

		male may have failed to conform to the standards of acceptable and prevailing medical practice in NC. MD saw the patient regarding an enlarged left cervical lymph node secondary to a viral infection. In addition, Patient had a mid-line neck mass and three plantar warts on his feet. MD recommended that Patient undergo removal of the cervical lymph node, mid-line neck mass, and plantar warts. Approximately 9 months after surgery, Patient presented with complaints of uneven shoulders, decreased left shoulder strength, and chronic left shoulder pain. Patient was diagnosed with scoliosis and referred for physical therapy. However, after 7 months of physical therapy with only mild symptom improvement, an extensive workup revealed left trapezius palsy associated with a spinal accessory nerve injury. The Board's reviewing expert noted MD's failure to perform preoperative bloodwork, laboratory testing, and/or imaging prior to Patient's surgery. The reviewer also noted numerous deficiencies in MD's pre-operative documentation, including but not limited to failure to document: patient and family history, examination of other nodal basins, discussion of treatment options and potential operative risks and complications. Further, there is no documentation of a	

		neurological examination during the postoperative follow-up visit.	
MISCELLANEOUS ACTIONS			
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			