Adverse Actions Report July-August 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			
IKRAMELAHAI, Sasha Melissa (001013544), Lagrange, GA	7/9/2024	Ms. Ikramelahai fraudulently used the academic, professional, and personal information of a New Mexico PA to obtain a PA license in NC. Through false and deceptive means, she had the name on the NCCPA account of the New Mexico PA changed to reflect her name. Ms. Ikramelahai has never taken the Physician Assistant National Certifying Examination and has never been certified by NCCPA. She altered the New Mexico physician assistant license with her name. That document is fraudulent and does not reflect any records of the New Mexico Medical Board.	License annulled
SUMMARY SUSPENSIONS			
NONE			
REVOCATIONS			
BENTLEY, Keri Mcfarlane, MD (202003841) Knoxville, TN	7/3/2024	MD's felony conviction for Conspiracy to Distribute Buprenorphine, Benzodiazepines; Conspiracy to Falsify Medical Records; Conspiracy to Commit Wire and Health Care Fraud; Conspiracy to Commit Money Laundering; Monetary Transaction in Property Derived from Specified Unlawful Activity; and Laundering of Monetary Instruments resulted in the automatic revocation of her license issued by the Board.	Revocation of NC medical license
SUSPENSIONS			

DHAWAN, Surinder, MD (009701318) Cary, NC	7/20/2024	In October 2023, MD agreed, in a Consent Order with the Board, to schedule a comprehensive examination within three months of the effective date of the Consent Order. In January, MD submitted a letter notifying the Board that he would not be scheduling an appointment for a comprehensive examination. The Board summarily suspended MD's medical license. In February 2024, the Board conducted a hearing and upheld its Order of Summary Suspension.	Indefinite Suspension
MOHOMED, Fasil Ferris, MD (201000445) Lumberton, NC	7/12/2024	In August 2020, MD presented to NCPHP after suffering a manic episode that led to hospitalization. He entered a monitoring contract with NCPHP to facilitate his treatment and recovery from bipolar disorder. MD's participation with NCPHP was anonymous to the Board. In April 2022, NCPHP believed MD was unsafe to practice, and he was admitted for inpatient treatment. In June 2022, NCPHP cleared MD to return to work. MD reported for a shift at the hospital where he was employed and was later observed drinking alcohol at a convenience store a few blocks away from the hospital. When confronted by hospital staff, MD admitted to drinking alcohol and tested positive on a preliminary breath test. NCPHP subsequently broke its anonymity and reported MD to the Board. MD was admitted to a residential treatment center where he was diagnosed withalcohol use disorder severe. MD inactivated his NC medical license. In September 2022, MD failed to meet with NCPHP to sign a new monitoring contract. After	Indefinite Suspension

		multiple unsuccessful attempts to reach MD, NCPHP notified him that they would be closing his case due to his failure to sign a new monitoring contract with NCPHP.	
RAHULAN, Vijil Komanthakkal, MD (201202216) Grandville, MI	7/29/2024	In 2022 the Pennsylvania State Board of Medicine found that MD has not complied with a 2017 Consent Agreement. MD stated on his biennial registration application with the Pennsylvania Board that he did not hold licenses to practice a profession in any other jurisdiction and that he has not had disciplinary action taken against the professional or occupational licenses to practice the profession in any state or jurisdiction. MD's representations on his renewal applications were false and deceptive. His medical license has been suspended or revoked in several jurisdictions mainly reflecting his lack of compliance with medical board regulations.	Indefinite Suspension
SOSA, Rodney Wayne, MD (202102662) Southlake, TX	7/29/2024	From March through May 2019 MD worked for a telemedicine company, reviewing medical records and responding to questions from beneficiaries of federal health insurance programs to determine if they qualified for Durable Medical Equipment, medication, or genetic testing. He did not consult with, examine, or otherwise interact with these patients. In June 2023 MD plead guilty to one count of Conspiracy to Defraud the United States and to Make Materially False Statements. In March 2024 MD was sentenced to forty-six months in prison.	Indefinite Suspension
LIMITATIONS/CONDITIONS			
CARTER, Diana Andreea, MD	8/5/2024	MD has a disciplinary history with	License reinstated

(201700648) Jacksonville, NC		the Board concerning allegations of boundary violations involving a patient, writing a prescription on her former employer's prescription blank, inappropriate prescribing of controlled substances, and making false statements or representations to the Board. In May 2023, MD self-referred to the North Carolina Professionals Health Program. She successfully completed inpatient treatment for Alcohol Use Disorder-Moderate in August 2023. Subsequently, MD signed a five-year monitoring contract with NCPHP. MD is currently in compliance with her NCPHP contract and NCPHP supports the reinstatement of MD's medical license.	with terms and conditions
KUMAR, Pankaj, MD (201401466) Winston-Salem, NC	7/31/2024	In March 2024, MD entered into a Consent Order with the Board that indefinitely suspended his NC medical license retroactively, effective June 27, 2023. MD is currently in compliance with his NCPHP contract and NCPHP supports the reinstatement of his medical license.	License issued with terms and conditions
REPRIMANDS			
MIRZAZADEH, Majid, MD (200802039) Winston Salem, NC	7/23/2024	MD was the attending physician in three urologic procedures involving kidney stones. A fifth-year urology resident physician began Patient A's surgery while MD was off-site at the mobile lithotripsy center performing Patient B's procedure. A separate fourth-year urology resident was involved in Patient C's procedure. The hospital's overlapping surgery policy required the attending surgeon to actively supervise or participate in the	Reprimand

		performance of each case. MD acknowledges that the overlap in scheduling was too close, considering the potential for unanticipated event and is no longer scheduling procedures in this manner.	
PULLIAM, Thomas Jackson, MD (000029375) Winston Salem, NC	7/1/2024	MD worked for approximately one week at a healthcare facility before he was terminated from his assignment after multiple complaints from patients and staff. The day after his termination, MD sent a text message to a representative of his locum tenens company which was interpreted as a possible death threat against the physician who had advised MD of his termination the day before.	Reprimand; MD shall comply with terms and conditions
ROBINSON, David Brian (009601047) Washington, IN	8/14/2024	Four years after an exploratory laparotomy a CT scan revealed the left ureteral stent from the procedure on Patient A was retained. A cystoscopy and stent removal were performed on Patient A to remove the retained and forgotten left ureteral stent. The Board's reviewing expert found that MD's care of Patient A, including treatment, maintenance of records, and overall care failed to conform to the standard of care. One year after MD performed a colonoscopy and digital rectal exam of Patient B a CT scan showed a seven-centimeter rectal mass. The Board's reviewing expert found that MD's care of Patient B, including diagnosis, treatment, and overall care failed to conform to the standard of care	Reprimand; MD will complete 8 hours Category I CME
DENIALS OF LICENSE/APPROVAL			
FUSIA, Tod Joseph, MD	8/5/2024	MD applied for a North Carolina	Denial of licensure

(FUSIQPAS6Q) Sugar Mountain, NC		medical license in October 2022. In response to specific questioning, MD failed to disclose disciplinary action taken by the Florida Board in 2007 and that in 2020 the Credentialing Committee of a health insurance company denied him credentialing privileges due to his malpractice claims history. MD's failure to disclose required information on his medical license application constitutes making false statements or representations to the Board in connection with an application.	
WHITE, Anne Litton, MD (000029552) Bermuda Run, NC	8/14/2024	MD has a lengthy disciplinary history with the Board. A suspension in February 2005 was based on allegations of billing for services that were not performed. Allegations of unprofessional conduct led to a July 2005 suspension. A May 2009 reprimand was based on allegations of advertising in a misleading manner. A 2018 summary suspension was based on allegations of MD's use of contaminated needles and/or syringes. A 2019 Order to pay a fine was based on MD's refusal to refund a patient's payment. In March 2021 MD was convicted of a misdemeanor for making false statements in applications for insurance which resulted in a March 2022 indefinite suspension by the Board. The Indiana and South Carolina Medical Boards took reciprocal actions in 2020 and 2022 respectively.	Denial of licensure
SURRENDERS			
COLLINS, Gregory Vincent, MD (000029094) Charlotte, NC	8/10/2024	MD voluntarily surrendered his license to practice medicine in North Carolina.	Voluntary surrender of medical license
PUBLIC LETTERS OF CONCERN			

ASH, Toland Lanier, MD (202402318) Hollywood, FL	8/13/2024	The Board is concerned regarding MD's disciplinary history with other state medical boards and criminal history. In a 2007 Consent Order, the Louisiana Board placed MD on probation with agreement not to practice medicine in Louisiana. As a result of the Louisiana Board's action, the Illinois, Florida and Georgia medical boards took action, which were later liftedIn July 2012, MD pled guilty to Unlawful Dispensing of Controlled Substances.MD was convicted of DUI and probation violation in Florida in 2015. As a result of the previous disciplinary actions and the 2012 federal conviction, MD was granted a medical license with a citation and warning by the Iowa Board in 2022. The Board recognizes that MD has successfully completed all probationary requirements and currently holds an active license to practice medicine in at least ten states and the District of Columbia and has been practicing safely for the past nine years.	License issued with Public Letter of Concern
CARROLL, Mark William, MD (000039925) Fort Mill, SC	8/29/2024	The Board is concerned about MD's care of a 23-year-old female who presented to an emergency department where MD was the attending physician, with a complaint of a puncture wound to the back of the head after being struck with a high-heeled shoe. MD's initial reading of X-ray imaging documented that no fracture was seen, but there was an abnormal finding suggestive of a foreign object in the left temporal area.After re-examining Patient, MD felt that an emergent CT scan was not needed. MD performed a staple repair of the scalp laceration and	Public Letter of Concern

		told Patient to follow up in seven days for suture removal.. The following day, radiology finalized the read and interpreted the X-ray imaging as revealing a foreign body that could be a knife blade in the posterior superior left orbit and documented that further evaluation was needed. However, there is no evidence that the radiologist contacted MD or any other physician within the emergency department regarding these findings or that Patient was subsequently contacted. The Board's reviewing expert noted that there was no documentation that MD explored the wound from the injury before repairing it.. MD also failed to document that he saw the foreign body on the X-ray imaging, and he did not record conducting any physical examination, including palpation of the facial area after viewing the foreign body on the film. If MD did indeed see the foreign body on the imaging, MD should have modified the treatment plan to further determine where and what the foreign object was and to ensure proper follow-up with a specialist.	
CROOK, Jennifer Lee, MD (202001138) Winston-Salem, NC	8/26/2024	The Board is concerned that in October 2021, MD failed to appreciate the findings of a PET scan performed on a Patient that strongly suggested progressive metastatic melanoma. The Board is also concerned about the timeframe by which MD scheduled Patient's follow-up care and repeat imaging given the PET scan findings which indicated both an enlarged lymph node and a new spot in the T-10 vertebral body In the opinion of	Public Letter of Concern

		the reviewing expert, waiting twelve months for repeat imaging in a patient with metastatic disease, enlarged lymph node, and evidence of new involvement in the vertebral body, was too long.	
DORNIC, Demetrian Ivan, MD (009800513) Smithfield, NC	7/23/2024	At the beginning of the COVID-19 pandemic, MD suspended the practice of one day post-operative visits for cataract surgery and eliminated the medical scribe position in his practice. MD performed laser assisted cataract surgery with multifocal lens implant on a patient and MD's surgical notes indicate that after the lens was inserted a defectin the capsular bag was discovered and the lens had to be manipulated into position. Per the hospital notes and Patient's statement, a postoperative follow-up appointment was not scheduled preoperatively but deferred to be scheduled later. Additionally, there was no documentation reflecting MD's conversation with Patient that he encountered a defect intraoperatively. The reviewing expert felt that MD should have better documented his discussion with the patient about surgical complications , and should have considered postoperative care within the first 24 hours after surgery.	Public Letter of Concern; MD will complete CME in communication and medical record keeping
ECKERT, Matthew Joseph, MD (202004130) Chapel Hill, NC	8/23/2024	MD performed a complete abdominal wall reconstruction with mesh. At the conclusion, MD was advised by operating room staff that all sponges, needles, and other surgical instruments were accounted for. Five days post-op, Patient complained of a new onset of severe scrotal pain and swelling of his right testicle.	Public Letter of Concern

		A large malleable retractor was found in the anterior abdominal wall. The Board's reviewing expert noted that inadvertently leaving surgical instruments inside a patient is below the standard of care for surgery. Diagnosis of the retained instrument and the patient's long-term issues because of the retained retractor were exacerbated by poor documentation and follow-up during the postoperative period, which falls below standard of care.	
EWARDS, III, John Sawyer, PA-C (000102395) Fort Bragg, NC	7/1/2024	The Board is concerned that in January 2024, the Washington Board required PA to complete a continuing medical education course on boundaries and ethics and pay a fine. This action was based on PA's asking an inappropriate question regarding a patient's tongue piercing during a strep throat examination.	Public Letter of Concern
GO, Michelle Sy, MD (201800679) Durham, NC	8/12/2024	The Board is concerned that MD's care of an 8-year-old female patient may have failed to conform to the standard of care. In 2021 Patient presented to undergo a laser procedure on her right eye, using YAG capsulotomy, to remove posterior capsule opacification. The Board's independent medical expert reviewed MD's care of the patient and criticized her failure to recognize during the procedure that the aiming beams were not the standard aiming beams found on YAG lasers, which suggests lack of essential knowledge about the principles of laser capsulotomy.	Public Letter of Concern; MD will complete four hours Category I CME
HARPER, Nathan Russell, MD (201402260) Greenville, NC	8/30/2024	Due to injuries sustained during a single-vehicle accident, MD was transported to a local hospital,	Public Letter of Concern

		which is within the same hospital system as he is employed. MD was cited for DWI and a blood test revealed his blood alcohol content exceeded the standard for gross impairment. While at the hospital, MD was observed accessing the computer in his hospital room. During the Board's investigation, it was confirmed that MD signed into the hospital computer system, accessed several patient records, co-signed clinical notes, and modified one patient record. The Board notes that the actions taken by MD appeared to be within his normal duties and that there was no patient harm. However, it was inappropriate for MD to access patient records and perform any duties while under the influence.	
JAROSZ, Todd Stephen (200601748) Lexington, KY	8/26/2024	The Board is concerned about MD's care of a 50-year-old female with a history of bilateral knee osteoarthritis for which total knee replacements were recommended. MD was the orthopedic surgeon who previously performed a successful left total knee replacement on the patient. In 2021, MD performed a right total knee replacement. During the procedure, he implanted a left femoral component into Patient's right knee. MD indicated that, immediately before proceeding with surgery, he performed a surgeon-led time out to confirm the patient, procedure, and side. He also confirmed with the implant manufacturer's representative, who was present for the surgery, that he had the correct-sided implant. Upon receiving confirmation, MD initiated surgery. During the	Public Letter of Concern

		procedure, the device representative handed MD what he believed was a left femoral component instead of right femoral component. He assured MD once more that MD was given the correct component. While the patient was in the recovery room, MD confirmed that a wrong-sided component had been placed and immediately informed the patient. The Board's reviewing expert opined that it is ultimately the surgeon's responsibility to ensure the correct implants are available before beginning a case by verbally confirming the implants by size, visually confirming before opening and having them placed on the sterile field and conducting a final check as the prosthetic components are implanted into the patient.	
JENNINGS, Randall Wayne, MD (201300915) Leesville, LA	7/24/2024	The Board is concerned that MD's care of a patient during a right knee replacement may have failed to conform to the standard of care. While placing the cutting guide MD inadvertently perforated the back protective layer of the thigh bone. MD did not realize this. Nursing notes indicate that MD was informed later that day that Patient was experiencing pain in the right ankle area and that her foot was dusky and cold, but there were detectable pulses in her right foot, although they were weak. MD did not return to evaluate Patient at that time. The next morning Patient's right foot was pale with no detectable pulse. MD returned to evaluate Patient. An ultrasound revealed a blockage of the mid-right superficial femoral artery, which	Public Letter of Concern

		delivers blood to the lower leg. Patient was transferred to the closest facility with vascular service and a procedure to restore blood flow to the mid-right superficial femoral artery was unsuccessful and Patient's right leg was amputated above the knee.	
JOHNSON, Jeremy Clyde, MD (009901552) Laguna Beach, CA	7/23/2024	The Board is concerned that MD's radiographic care of a patient may have fallen below the standard of care. Four months after MD examined and reviewed x-rays of a 50-year-old patient with right anterior knee pain, she saw another provider in MD's practice who reviewed her previous x-rays and saw a large cyst within the medial femoral condyle. New x-rays showed advancement of the cyst to the cortical borders of the medial femoral condyle and severe thinning of the cortical border. An MRI showed a large, aggressive enhancing mass in the medial femoral condyle concerning for malignancy. The final diagnosis was non-cancerous giant cell tumor. The standard of practice would have been to read the x-ray correctly and make the appropriate referral to an orthopedic oncology specialist.	Public Letter of Concern
JOYNER, Patrick Wakefield, MD (201400960) Naples, FL	8/12/2024	The Board is concerned that MD's care of a patient may have failed to conform to the standard of care. While MD's diagnosis of elbow pain secondary to post traumatic arthritis was appropriate, his diagnosis related to elbow function and motion was deficient. The Board's reviewing expert opined that a 20-degree change in flexion is not sufficient to warrant surgical	Public Letter of Concern

		intervention. The reviewing expert criticized MD's operative technique of an anterior capsular debridement which poses risk to neurovascular structures. The reviewing expert criticized MD's decision to debride tissue anteriorly and laterally as this is where the radial nerve is most at risk. MD had his care reviewed by an independent expert who opined that MD did not breach the prevailing standard of care because the patient was well informed on the risks and complications of an elbow procedure, and the surgery proceeded at the request of the patient.	
PHAM, Justin Hung, MD (200700652) Scottsdale, AZ	7/23/2024	The Board is concerned that MD's care of a 98-year-old female who fell at a nursing home may have failed to conform to the standard of care. MD interpreted and dictated reports on two x-ray views of Patient's left hip. He interpreted the left hip films as a single, unilateral view, when in fact, there were two views. Neither of the films were interpreted to show a left hip fracture. Patient was later taken to a physician who suspected an occult fracture based on his examination. A pelvic CT was obtained, and the physician diagnosed a pelvic fracture that MD reported was not apparent.. The Board's independent medical expert indicated that the films MD interpreted were of adequate quality to visualize the severe left hip/pelvic fracture.	Public Letter of Concern
SIVARAJ, Thamotharampillai, MD (009901648) Hialeah, FL	7/18/2024	The Board is concerned that in December 2023, the Florida Board issued MD a letter of concern, imposed a fine, and	Public Letter of Concern

		required continuing medical education on diagnosis and treatment of cerebrovascular events and risk management. The Florida Board's action was based on MD's failure to conform to the standard of care during his care of a patient who presented to the emergency department complaining of dizziness, headache, numbness and tingling over the right hand, and hypertension. MD failed to order a CT scan and discharged the patient the following day. Two days later Patient returned to the emergency department with complaints of right-side weakness, slurred speech, and unsteady gait. A different provider ordered a CT scan which revealed an acute cerebrovascular event had occurred. The Florida Board alleged MD violated the prevailing professional standard which required a CT scan to evaluate for a possible cerebrovascular accident.	
STARKS, LaWanna Marie (200600525) Durham, NC	7/22/2024	The Board received a complaint from MD's employer related to prescribing controlled substances to an immediate family member, which is prohibited. The employer's internal investigation revealed, and MD admitted, that she inappropriately prescribed Adderall and alprazolam (Xanax) to an immediate family member. During the Board's investigation, it was revealed that MD also prescribed two non-controlled substances to her immediate family, without establishing an appropriate physician-patient relationship. MD immediately stopped prescribing medications to her immediate family member	Public Letter of Concern

		once it was brought to her attention by the employer.	
VAN LEEUWEN, Dirk Jacob, MD (201700527) Oshkosh, WI	7/26/2024	The Board is concerned that in 2021 MD performed a breast examination on a patient that she perceived as unnecessary and without a chaperone. Patient presented to MD's gastroenterology practice complaining of right upper quadrant pain. The patient claimed that MD told her he would examine her abdomen and asked her to lie down on the examination table. She alleged that MD used both hands to palpate her breasts atop her clothing and asked her if she had regular mammograms. This occurred while MD had an Oregon Visiting Physician License under the COVID-19 state of emergency and practiced under a locum contract. The Oregon Medical Board investigated the patient's allegations. MD completed a professional boundaries course and withdrew his application for a permanent Oregon license. The Oregon Board subsequently closed its investigation.	Public Letter of Concern
MISCELLANEOUS ACTIONS			
BOYD, Lillian Kizer, MD (201100137) Goldsboro, NC	8/16/2024	MD has fulfilled the requirements set forth in her Reentry Agreement	Reentry Completion
KARDON, Evan Peter, MD 000039834) Raleigh, NC	7/3/2024	MD self-reported to the Board that he was under investigation by the Office of Inspector General (OIG), regarding billing practices that occurred while he was working in telemedicine. In January 2024, MD entered into a	License inactivated effective February 7, 2024

		settlement agreement with OIG in which he agreed to pay over $200,000 for reimbursement to federal health insurance programs for false claims. MD also agreed to be excluded from participation in all Federal health care programs for ten years. On February 7, 2024, MD inactivated his North Carolina medical license while under investigation by the Board.	
SCOTT, George Richard, MD (009700392) Lynchburg, VA	7/26/2024	MD has fulfilled requirements set forth in his Reentry Agreement.	Reentry Completion
TREVINO, Lisa Verionica, PA-C (001013635)	8/2/2024	PA has fulfilled the requirements set forth in her Reentry Agreement.	Reentry completion
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
CUNHA de ARAUJO, Raphael Leonardo, MD (202402127) Charlotte, NC	7/25/2024	The Board issued MD a Special Purpose License to practice medicine and surgery in NC effective July 29, 2024, thru July 28, 2025. MD agrees to not practice medicine outside the limitations set forth in the Agreement. This limitation includes his participation in training of robotic HPB surgical procedures at Atrium Health-Carolinas Medical Center.	Special Purpose License issued
SIALA, Selima, MD (202301860) Ariana, NC	7/26/2024	MD was initially issued a Special Purpose License dated June 26, 2023. MD's Special Purpose License permitted her to be a clinical fellow at the University of North Carolina, Division of Cardiothoracic Imaging, Department of Radiology, beginning August 1, 2023, and	Amended Special Purpose License Agreement

		ending on July 31, 2024. MD seeks a two-year extension of her Special Purpose License to complete a one-year Cross-Sectional Imaging Fellowship to be followed by a one-year Accreditation Council for Graduate Medical Education Accredited Neuroradiology Fellowship at the University of North Carolina at Chapel Hill. The Board shall extend the timeframe of MD's Special Purpose License. The Special Purpose License shall come into effect August 14, 2024, and shall expire on August 13, 2026;	
RAZ YARKONI, Tom, MD (202402191) Chapel Hill, NC	8/1/2024	The Board issued MD a Special Purpose License to practice medicine and surgery in NC effective July 1, 2024, thru July 5, 2025. MD agrees to not practice medicine outside the limitations set forth in the Agreement. This limitation includes MD's participation in the NeuroRhinology - Advanced Rhinology and Skull Base Surgery Fellowship at UNC.	Special Purpose License Issued
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			