Adverse Actions Report January-February 2026

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			
NONE			
REVOCATIONS			
ABDELFATTAH, Nizar Fathallah Saleh, MD (RTL201029) Durham, NC	1/9/2026	MD's felony convictions in California for one count of Forcible Rape and one count of Sexual Penetration by Foreign Object resulted in the automatic revocation of his license issued by the Board, unless the Board received a request for a hearing from MD within 60 days of receipt of notice. Having received no request for a hearing the Board revoked MD's license.	Revocation of NC Medical License
CARTER, Joshua Matthew, PA (001007232) Charleston, SC	1/14/2026	In August 2024, PA pleaded guilty in a Charleston, SC court to Second Degree Assault and Battery. PA was Reprimanded in November 2024 by this Board and fined $1,000 imposing reciprocal discipline for a 2022 Virginia Board Order which found that PA had written fraudulent prescriptions for controlled substances for his friends. The 2024 Board action also disciplined PA for not disclosing the Virginia Board investigation on his 2022 and 2023 annual license renewal forms with this Board. PA did not comply with the terms of the 2024 Consent Order. In	

		December 2024, the Board ordered a comprehensive examination by NCPHP, which he failed to complete.	
JACKSON, Anita Louise, MD (009700991) Rockingham NC	2/13/2026	MD's felony conviction for Adulteration of Medical Devices with Intent to Defraud and Mislead, Illegal Remunerations and Aiding and Abetting, False Statements Relating to Health Care Benefits and Aiding and Abetting, Aggravated Identity Theft and Aiding and Abetting, Mail Fraud and Aiding and Abetting, and Conspiracy.	Revocation of NC medical license
SMITH, Alleyne Patricia, MD (009500450) Salt Lake City, UT	2/27/2026	MD's felony conviction for one count of Conspiracy to Commit Health Care Fraud	Revocation of NC medical license
SUSPENSIONS			
NONE			
LIMITATIONS/CONDITIONS			
HADI, Samir, MD (202600137) Las Vegas, NV	1/13/2026	MD applied for his NC medical license in January 2025. In March 2025, the Nevada Medical Board issued MD a Public Letter of Reprimand and fine. As part of his agreement with the Nevada Board, MD acknowledged that sufficient evidence may have been presented that would have allowed the Nevada Board to conclude that he had committed malpractice as set forth in Nevada Revised Statute. MD completed all terms of the Settlement Agreement as of March 24, 2025.	Medical license issued; MD is prohibited from practicing interventional radiology in NC
PERROTTA, Philip Saverio, PA-C (000102805) Aberdeen, NC	1/15/2026	PA has not practiced since December 2022 and inactivated his NC physician assistant license in January 2023 at the request of the	PA license reinstated with terms and conditions

		Board. His license was indefinitely suspended in August 2023 based on concerns related to PA's opioid use relapse, prescribing opioids to a patient, purchasing a portion of those opioids from the patient, and keeping a patient's unused oxycodone for personal use. An NCPHP assessment in December 2022 recommended that he participate in residential treatment due to being diagnosed with Severe Opioid Use Disorder. PA successfully completed residential treatment in March 2023. Since December 2022, PA has maintained sobriety and in March 2023, entered into a five-year monitoring contract with NCPHP. NCPHP supports his return to practice.	
REPRIMANDS			
GROSSLIGHT, Kenneth Russell, MD (200601402) West Columbia, SC	1/13/2026	Patient underwent an outpatient surgical procedure for placement of an intrathecal pain pump and catheter. Patient presented to MD to have the pain pump programmed and loaded with opioid pain medicine for proper infusion. MD failed to reduce the infusion rate and properly set the intrathecal pain pump to the correct dosage of opioid morphine medication. The next morning, Patient became non-responsive. After being admitted to a hospital, it was determined that Patient	Reprimand

		was suffering from opiate overdose from the pain pump.	
MISHRA, Shashank, MD (200301021) Charlotte, NC	2/10/2026	In October 2024 MD's license was indefinitely suspended for writing unauthorized phentermine prescriptions for himself. MD applied for reinstatement of his medical license in May 2025 and, in September 2025 he admitted to his therapist that in July 2025, he self-prescribed prednisone to treat a gout flareup despite not holding an active medical license. MD admitted to NCPHP that he self-prescribed prednisone in 2024 and acyclovir in 2025 without having an active medical license.	Reprimand
PARKS, Daniel Emery, MD (009500175) New London, NH	1/20/2026	In May 2025, the Virginia Board Reprimanded MD and required him to complete CME in professional boundaries. The Virginia Board's action was based on findings of negligence, unethical conduct, sexual boundary violations, and violations of Virginia Board statutes and regulations. While employed at a Virginia medical facility, MD treated a female front-desk employee. After Patient left employment, MD continued personal contact with her, continued to provide medical treatment, and prescribed medications without documenting the treatment in her medical record. The Virginia Board found that MD and Patient developed a flirtatious	Reprimand

		relationship, communicated by text message, met socially in person, and engaged in sexual encounters between 2020 and 2022. Also, MD repeatedly accessed Patient's medical record between 2022 and 2023 without a legitimate medical purpose. Although MD asserted that he accessed Patient's chart for medical reasons, he admitted his personal contacts with Patient were inappropriate. MD completed the CME requirements imposed by the Virginia Board and Virginia terminated its prior Order upon confirmation of MD's compliance. NCPHP made no recommendations, following an assessment, and supported MD's continued medical practice.	
DENIALS OF LICENSE/APPROVAL			
KONESWARAN, Suresh Aravinth, MD (201400260) Greensboro, NC	2/12/2026	MD's license has been inactive since November 2022, when he was indefinitely suspended. MD was first issued an NC medical license in 2014. MD failed to disclose prior complaints, the findings of a comprehensive examination, and the recommendations of a treatment center at the time he submitted his initial license application in 2013. The evidence before the Board indicated that there were at least six patients or individuals who complained of inappropriate conduct of a sexual nature by MD in the course of treatment or	Application for reinstatement of license denied

		medical studies occurring over more than a decade and that some of these complaints concerned conduct that occurred after MD participated in treatment to address his troubling behavior.	
SURRENDERS			
NONE			
PUBLIC LETTERS OF CONCERN			
AMICO, Frank Joseph, Jr, DO (201500031) Camden, NC	2/20/2026	The Board is concerned that in June 2025 DO was fined by the Virginia Board and required to take CME on the subject of professional boundaries. The Virginia Board found that DO violated physician-patient boundaries by becoming inappropriately involved with patients outside of a professional setting for DO's own personal benefit, and prescribed medication to an immediate family member. The Board notes that in November 2025, the Virginia Board closed this matter due to DO's compliance with the requirements of the June 2025 Order.	Public Letter of Concern
BEDNAR, Edward Joseph, MD (000032338) Charlotte, NC	2/25/2026	The Board is concerned about MD's care of Patients A-E who underwent liposuction and fat grafting at his practice. Specifically, an in-person visit 3-6 months after surgery did not take place for Patients B-E. Communication between the office and all five patients in the weeks and months following the procedure) was not sufficient to adequately address patient concerns,	Public Letter of Concern

		and the photos sent by the patients do not allow for accurate postoperative assessments. There are concerns regarding the timing of the administration of the preoperative sedating medications for all five patients. Due to a lack of documented time stamps on some of the forms, the reviewer was concerned that it could not be determined whether medications that could have had a sedating effect were given prior to the pre-anesthesia visit for some of the patients. MD's documentation did not meet the applicable standard of care in NC.	
HARRINGTON, Michael Kenneth, MD (201501809) Charlotte, NC	1/13/2026	The Board's investigation determined that MD had a romantic relationship for approximately two years with Patient A. The Board is concerned that from August 2023 to March 2025, MD ordered non-controlled prescriptions five times for Patient A. Additionally, MD ordered two non-controlled prescriptions for Patient B, an employee at another med spa where MD serves as Medical Director. MD failed to have a proper physician-patient relationship with Patients A and B, keep a medical record, or otherwise document prescriptions.	Public Letter of Concern
KELSO, Thomas Benton, II, MD 200300626) Shallotte, NC	1/9/2026	The Board is concerned that during a reverse total shoulder arthroplasty surgery on a patient, a periprosthetic humeral shaft	Public Letter of Concern

		fracture occurred. Recognizing the complication, MD extended the incision and repaired the internal fracture with a plate, several screws, and cerclage wire. Following surgery, Patient was noted to have signs and symptoms of radial nerve palsy. Electromyogram (EMG) and nerve conduction studies (NCS) showed a complete radial nerve lesion below the tricep with some activity in the brachioradialis muscle in the forearm. MD recommended continued observation. Patient continued to have symptoms of radial nerve palsy and EMG and NCS studies were repeated with continued observation recommended by MD and a colleague who provided a second opinion. Approximately a year after surgery Patient was seen at the Mayo Clinic for a third opinion. An ultrasound showed that the radial nerve was entrapped or transected by one of the cerclage cables MD placed during his surgery the prior year. The cable was removed along with neurolysis and tendon transfer. The Board's reviewing expert was concerned because the possibility of radial nerve entrapment by the fixation device should have been further investigated.	

KOLB, Terence William, MD (201101538) Panama City Beach, FL	2/11/2026	As a result of a complaint filed with the Board regarding one of MD's APPs, the Board attempted to contact him on multiple occasions without receiving a response. It took several months to reach MD due to his failure to update his contact information with the Board. When investigating the case against the APP, the Board became concerned about MD's supervision of his APPs. Specifically, the Board sought information about whether MD conducted quality improvement (QI) meetings as required per 21 NCAC 32S.0213(e) and whether he had in place the appropriate written supervisory arrangements with his APPs. The Board found largely that the QI documents were sparse and difficult to read. In some instances, no QI meeting documents were produced.	Public Letter of Concern
LAFATA, John Anthony, DO (09801692) Clyde, NC	2/26/2026	The Board is concerned about allegations of substandard care and poor communication in MD's care of a patient. Prior to Patient's initial consultation with MD, she was being treated with Prolia injections for post-menopausal women who are at high risk for fracture, and she was due for the next dose in October 2023. However, Patient did not receive another dose in October. Due to an unreadable test result and retesting, MD next	Public Letter of Concern; DO will complete a minimum of 4 hours Category I CME

		addressed the osteoporosis result with Patient in January 2024 and referred her to a rheumatologist. Unfortunately, Patient suffered a series of three vertebral compression fractures that month. The Board's reviewing expert found the diagnosis and treatment of Patient may have fallen below the standard of care in NC due to the delay in recognizing and addressing Patient's condition. The standard of care would have been to promptly request a readable report.	
LOGAN, Jenalyn Kay, PA-C (001000229) Wendell, NC	2/20/2026	The Board is concerned about PA's care of a patient who presented to the emergency room after sustaining a significant right knee laceration. PA cleaned, explored, and sutured Patient's laceration while in the emergency room. PA concluded the X-ray did not show any evidence of a foreign body or fracture and determined consulting orthopedics was unnecessary. Patient was discharged home on oral antibiotics and pain medications with instructions to follow-up with an outpatient orthopedic clinic. Patient returned to the emergency room two days later and was admitted with diagnoses of right knee pyogenic arthritis and sepsis. A CT scan revealed injury to the patellar tendon and gas lucencies within	Public Letter of Concern

		Patient's right knee joint and he underwent a right knee arthrotomy and patellar tendon repair. Patient required significant pain management and was scheduled for multiple follow-ups with both orthopedic and infectious disease specialists over the following months. The Board's reviewing expert believes further testing should have been performed to rule out joint involvement of the laceration. This would require an operating room washout and closure by an orthopedic specialist. The expert opined that this type of closure would exceed the scope of practice for an emergency medicine provider. The bedside irrigation and layered wound closure were also insufficient.	
MERRILL, Lisa Christine, MD (202600990) Williamsburg, VA	2/26/2026	The Board is concerned that in 2024 the Virginia Board reprimanded MD after erroneously entering a Do Not Resuscitate/Do Not Intubate order for an elderly hospitalized patient without properly documenting the patient's wife's consent or ensuring that a witness was present during the critical end-of-life discussion. Patient had been admitted as full code, and the change in status was made under MD's mistaken belief that authorization had been given by the patient's wife. Patient subsequently passed away without resuscitative	License issued with Public Letter of Concern

		efforts being initiated, leading to distress for the family and a finding by the Virginia Board that warranted a formal reprimand. The failure to adequately document consent and ensure corroboration during such a consequential discussion represents a serious lapse in professional judgment. MD has since changed her practices to ensure that witnesses are present during code status discussions and MD now documents these discussions and agreements in the patient's chart.	
MILLENDER, Tarra Wright, MD (200700722) Southern Pines, NC	2/11/2026	The Board received an anonymous complaint reporting that MD prescribed Diazepam, a Schedule IV controlled substance, to an immediate family member (Person A). Person A's prescription history showed MD prescribed thirty tablets of 10 mg Diazepam in July 2024. MD confirmed that she prescribed the controlled substance to Person A to treat what she believed to be serotonin syndrome. It is MD's position that Person A's primary care provider was unavailable to prescribe the medication. Board Rule 21 NCAC 32B.1001 prohibits the prescribing of controlled substances to a physician's immediate family, which MD violated.	Public Letter of Concern

SCHWARZ, Ronald Paul, MD (000023969) Raleigh, NC	1/5/2026	The Board is concerned that MD's care of a patient during a routine screening colonoscopy failed to the standard of care. During early insertion of the colonoscope, MD identified a 1 cm mucosal laceration in the sigmoid colon and closed the tear using 3 metal scope clips. Despite the known perforation, MD elected to proceed with and complete the colonoscopy. Post procedure, MD discharged Patient with antibiotics and instructions for a clear liquid diet. Later that day, Patient developed worsening abdominal pain and presented to the emergency department. CT imaging revealed a large amount of free-flowing air in the abdominal cavity. Patient underwent laparoscopic primary repair of the sigmoid colon perforation and abdominal washout. The Board's reviewing expert concluded that, while perforation was recognized promptly and closure was appropriate, several aspects of MD's care fell below the minimum standard of care. The Board acknowledges that MD inactivated his NC medical license and has retired from medical practice during this investigation.	Public Letter of Concern
WELLER, Edward Brooks, MD (201401559) Charlotte, NC	2/19/2026	The Board is concerned that MD's care of a Patient may have failed to conform to the standards of care. A patient presented for kneecap repair surgery on	Public Letter of Concern

		her left knee including the cutting of the shinbone, replacement of the ligament that joins the kneecap and thigh bone, repositioning of the patella, and cartilage repair. In preparation for the procedure, MD administered a nerve block to the right lower extremity, not the left. Patient's mother immediately went to nurses' station to question the procedure and the error of the nerve block being administered to the wrong side was realized. MD subsequently administered the nerve block to the left lower extremity and Patient was able to proceed with the planned surgery without further incident. The Board notes that the anesthesia record only indicates that a nerve block was administered to the right lower extremity, immediately followed by a second block to the left lower extremity. There is no documentation in the medical record detailing the error that occurred. The Board recognizes that the Patient replied "yes" when asked if the procedure was for the right side. However, Patient was a minor, and her mother was not asked to confirm the correct surgical extremity. The Board is further concerned that a request was made for MD to speak with Patient's father after the procedure and MD neglected to do so.	

WON, John Sunghoon, MD (200601944) Durham, NC	2/26/2026	The Board is concerned about MD's care of a patient who presented for a dental procedure at his office. After sedation was administered, MD and others assisting with the procedure proceeded to mock Patient's weight and intelligence. Allowing other members of the treatment team to participate in such behavior is also unprofessional.	Public Letter of Concern
ZIMMERMAN, James RobertM, MD (200201209) Roswell, GA	2/24/2026	The Board is concerned about MD's care of Patient A, who underwent a radiograph of his right fifth finger. MD reported this as an old fracture with no acute fracture, dislocation, or bony erosion. At a clinic appointment a few weeks later, Patient A was allegedly informed that his finger was broken and would need to be rebroken and set. Patient B had his right foot and ankle x-rayed; MD read Patient B's radiograph and failed to diagnose fractures that caused a delay in treatment and permanent injuries. MD self-reported on his 2018 NC license renewal application that his employer suspended his clinical privileges due to alleged misinterpretation of two mammograms. Patient C and Patient D both had dense breast tissue, and MD interpreted the findings as benign. However, both women were subsequently diagnosed with breast cancer. MD's employer subjected his mammograms	Public Letter of Concern; MD shall complete nine hours Category I CME

		of Patients C and D to a peer review, which found MD's interpretive skills did not meet the standard of care his employer required. The Board ordered MD for a competency examination at the Center for Personalized Education for Professionals (CPEP). MD's CPEP assessment reported that there were moderate gaps in MD's knowledge and skills of mammography. Collegial support and oversight were suggested to ensure maintenance and/or re-acquisition of skills. It was noted that the American College of Radiology indicates that all interpreting physicians for mammography must meet initial and continuing Mammography Quality Standards Act (MQSA) requirements. The Board would anticipate that if MD plans to continue to read mammograms, he will ensure that he meets continuing MQSA requirements.	
MISCELLANEOUS ACTIONS			
NONE			
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			