

**Adverse Actions Report February 2020 – March 2020**

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](http://www.ncmedboard.org/BoardActions).

| Name/license #/location  | Date of action | Cause of action  | Board action          |
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| <b>ANNULMENTS</b>  |                |  |                       |
| <b>NONE</b>  |                |  |                       |
| <b>SUMMARY SUSPENSIONS</b>   |                |  |                       |
| <b>NONE</b>  |                |  |                       |
| <b>REVOCATIONS</b>   |                |  |                       |
| <b>NONE</b>  |                |  |                       |
| <b>SUSPENSIONS</b>   |                |  |                       |
| <b>CANDELA</b> , Stephen Joseph, MD<br>(000027776) Shallotte, NC   | 02/19/2020     | In July 2019, NCMB received a complaint forwarded by the Medical Board of California that alleged MD had engaged in sexual relations with a patient. During the course of the investigation, MD admitted to the allegation. MD inactivated his North Carolina medical license on August 1, 2019.   | Indefinite Suspension |
| <b>FLECHAS</b> , Jorge David, MD<br>(000024245) Hendersonville, NC | 02/14/2020     | In June 2019, the Board received a complaint alleging that MD had provided medical care and treatment, including prescribing a controlled substance, to an immediate family member. Prescribing controlled substances to an immediate family member is a violation of rule 21 NCAC 32B .1001(c).<br><br>The complaint was based on an investigation conducted by Child Protective Services | Indefinite Suspension |

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|   |            | division of the Department of Social Services in South Carolina which initiated its investigation after being contacted by hospital officials that MD's immediate family member had delivered a child born addicted to opiates, in April 2019.  |  |
| <b>RICCIARDELLI</b> , John James, MD<br>(201302305) Rocky Point, NY | 02/27/2020 | Action taken by another medical board; MD plead guilty to one count of felony Distribution of Oxycodone in the United States District Court for the Eastern District of New York in November 2018. In February 2019, the New York State Board for Professional Medical Conduct summarily suspended MD's New York medical license. In July 2019, the New York Board, entered a Determination and Order in which MD's New York medical license was suspended for 20 months, with all but two months stayed, and MD was permanently restricted from prescribing Schedule II controlled substances. Additionally, MD was placed on probation with a practice monitor for record review for a period of three years. | Indefinite Suspension                            |
| <b>RUSSELL</b> , David Norman, MD<br>(000025525) Salisbury, NC      | 02/11/2020 | In September 2018, MD informed the Board that he was involved in an ongoing administrative inquiry by the Internal  | Indefinite Suspension;<br>Stayed with conditions |

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|   |            | Revenue Service. In November 2018, MD voluntarily reported to the Board that he had entered a plea to a Federal Bill of Information referencing one count of Felony Attempt to Evade or Defeat Tax but had not been sentenced and was awaiting completion of the investigation by the Government.  |   |
| <b>SMITH</b> , Michael Lantry, MD (200301293) Kitty Hawk, NC    | 03/17/2020 | In October 2018, the Board received a complaint alleging that MD had treated a close family member. On the same day the complaint was made, MD contacted the Board to self-report that he had administered Toradol injections on multiple occasions to a close family member for chronic back pain in October 2018 and did not create a medical record for these treatments. | Suspension for 12 months, stayed; Reprimand and \$2,500 disciplinary fine.        |
| <b>LIMITATIONS/CONDITIONS</b>                                   |            |  |   |
| <b>DOUGHERTY</b> , Douglas Andrew, MD (200701126) Las Vegas, NV | 03/17/2020 | MD suffers from alcohol use disorder. In September 2018, MD was charged with his second DWI. He was referred to NCPHP for an evaluation and signed a 1-year monitoring contract in December 2018. In July 2019, MD had a positive phosphatidyl ethynyl test and thereafter completed eight weeks of residential treatment.   | Consent Order; MD shall maintain his agreement with NCPHP and abide by its terms. |

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|  |            | In October 2019, MD signed a five-year monitoring agreement with NCPHP and is in full compliance.   |  |
| <b>WOLFE</b> , William Ralph, MD (201302251)           | 03/04/2020 | MD's North Carolina medical license expired on January 20, 2015, due to non-renewal. In June 2018, the Board indefinitely suspended MD's license based on actions taken by the New Jersey State Board of Medical Examiners and the Pennsylvania State Board of Medicine. The actions were based on MD's alleged improper prescribing of controlled substances. MD's licenses were reinstated in June 2019 (New Jersey) and August 2019 (Pennsylvania) without restrictions after finding that MD did not violate the New Jersey Board's laws and regulations. | License reinstated. MD shall comply with the terms and conditions of his New Jersey Order. |
| <b>REPRIMANDS</b>                                      |            |   |  |
| <b>IMAM</b> , Naiyer, MD (200500428)<br>Woodbridge, NJ | 02/20/2020 | Standard of care issue with a patient who underwent a single view abdominal x-ray to verify proper placement of a percutaneous endoscopic gastrostomy ("PEG") tube. MD incorrectly interpreted the x-ray while positioning the PEG tube. It was discovered that the PEG tube was outside of the patient's stomach resulting in leakage of fluid into the peritoneal cavity, which created an abscess.   | Reprimand  |

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| <p><b>POWERS, Tonya Kim, MD</b><br/>(009801450) Shelby, NC</p>          | <p>03/17/2020</p> | <p>Action taken by another medical board; In July 2019 the Virginia Board of Medicine entered an order through which MD was reprimanded for inappropriate failing to follow Virginia prescribing regulations for controlled substances that became effective during her ongoing treatment of a patient. MD was ordered to satisfactorily complete 15 hours of continuing medical education in controlled substance prescribing and 15 hours in medical record keeping.</p>                 | <p>Reprimand</p>                |
| <p><b>DENIALS OF LICENSE/APPROVAL</b></p>                               |                   |  |                                 |
| <p><b>NONE</b></p>  |                   |  |                                 |
| <p><b>SURRENDERS</b></p>  |                   |  |                                 |
| <p><b>NONE</b></p>  |                   |  |                                 |
| <p><b>PUBLIC LETTERS OF CONCERN</b></p>                                 |                   |  |                                 |
| <p><b>ALEXANDER, Johnny Octavious, MD</b> (201101251) Beachwood, OH</p> | <p>02/18/2020</p> | <p>Quality of care issue regarding a patient who was transported to the emergency department with an altered mental status. A head CT scan was ordered. MD read the CT scan but failed to recognize or mention the presence of a dense middle cerebral artery (“MCA”), a finding that has long been established as the earliest, most reliable indicator of an acute stroke. Consequently, the patient did not receive pharmacologic or endovascular therapy for his acute stroke in a</p> | <p>Public Letter of Concern</p> |

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|   |            | timely manner. The patient subsequently required a craniotomy to treat cerebral edema and was discharged to hospice care where he passed away.   |                          |
| <b>DRESSLER</b> , Frederick Alexander, MD (200300143) Sylva, NC | 03/06/2020 | Quality of care issue. MD performed an angioplasty and attempted to place a stent in a patient using hydrophilic guidewires that migrated to the patient's head, causing a subarachnoid hemorrhage. MD failed to pay close attention to the perfusion status of the patient's lower extremities when aborting the procedure. This caused the lower extremities to begin necrosing and become nonviable, and ultimately caused the patient's death. | Public Letter of Concern |
| <b>MARTINEZ</b> , Paul Armando, MD (009300219) Apex, NC         | 03/06/2020 | Quality of care issue. MD provided treatment for a large left genital labial abscess, discharged the patient with instructions for home care and instructed her to follow-up with her primary care physician. Patient returned to the emergency department with continued complaints and was then diagnosed with necrotizing fasciitis.  | Public Letter of Concern |
| <b>PICTON</b> , Douglas William, MD (000036245) Greenville, NC  | 03/16/2020 | Quality of care issue. The Board is concerned that MD missed a superior mesenteric artery blood clot present in patient's  | Public Letter of Concern |

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|  |            | CT scan.  |                          |
| <b>ROGALSKI</b> , Matthew Joseph, MD<br>(201202347) Woonsocket, RI | 02/18/2020 | Quality of care issue. MD encountered a colpotomy complication during a Loop Electrosurgical Excision Procedure. Post procedure, the patient experienced complications and presented to an emergency department with severe generalized abdominal pain. The patient was taken to surgery, where a perforation of the small bowel was noted, and a small bowel resection was performed. The Board is concerned with lack of detail in the documentation of the patient's care and believes that, once the colpotomy was recognized, MD should have considered assessing the colpotomy using multiple laparoscopic visualization sites. | Public Letter of Concern |
| <b>SCHRANZ</b> , Craig Ian, MD<br>(201000182) Elizabeth City, NC   | 03/06/2020 | In September 2016, a patient presented to an emergency department with chest pain and acute back pain. The Board appreciates that MD provided an expert medical opinion and appropriate care but is of the opinion that MD should have considered obtaining a CT scan aortic dissection protocol and considered follow-up cardiac biomarker testing for   | Public Letter of Concern |

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|   |            | possible acute coronary syndrome prior to discharging patient.  |   |
| <b>WARD</b> , David Lee, MD<br>(200301528) Dallas, TX             | 02/04/2020 | The Board is concerned that MD failed to call the clinical team upon reading the results of an urgent MRI of a patient complaining of headache and eye pain. MD opined that the patient may have a possible brain bleed (subarachnoid hemorrhage) which is a critical finding that mandates expedient communication with the clinical team, usually by phone. Subsequently the patient continued to deteriorate and ultimately developed symptoms of a stroke and retrospective review of the MRI by a pediatric neurologist was interpreted to show evidence of a blood clot in the patient's brain. | Public Letter of Concern  |
| <b>MISCELLANEOUS ACTIONS</b>                                      |            |   |   |
| <b>NONE</b>   |            |   |   |
| <b>CONSENT ORDERS AMENDED</b>                                     |            |   |   |
| <b>OENBRINK</b> , Raymond Joseph, DO<br>(200901584) Asheville, NC | 03/16/2020 | In November 2019, DO requested that the Board remove the terms and conditions in paragraphs two through six of his 2014 order. The Board recognizes that DO has complied in all respects with the 2014 order and hereby removes paragraphs 1, 2, 3, 4, and 6. Paragraph 5, ensuring the presence of a patient chaperone, is still in effect until specifically  | Amended Findings of Fact, Conclusions of Law, and Order; Paragraphs 1-4, and 6 of DO's 2014 Order are hereby removed. |

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|  |  | ordered otherwise by<br>the Board. |  |
| <b>TEMPORARY/DATED LICENSES:<br/>ISSUED, EXTENDED, EXPIRED, OR<br/>REPLACED BY FULL LICENSES</b> |  |                                    |  |
| <b>NONE</b>  |  |                                    |  |
| <b>COURT APPEALS/STAYS</b>   |  |                                    |  |
| <b>NONE</b>  |  |                                    |  |
| <b>DISMISSALS</b>  |  |                                    |  |
| <b>NONE</b>  |  |                                    |  |