Adverse Actions Report May-June 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			
JORDAN, Richard Dean, MD (202303420) Statesville, NC	6/22/2026	MD's felony convictions for Second Degree Sexual Exploitation of a Minor; three counts of Second-Degree Sexual Exploitation of a Minor; First Degree Sexual Exploitation of a Minor and Indecent Liberties with a Child; and Felony Secret Peeping.	Revocation of NC medical license
SUSPENSIONS			
GUALTIERI, Camillo Thomas, MD (000018957) Chapel Hill, NC	6/17/2026	MD has a history of complaints from female patients about unwanted touching by MD and comments about their attractiveness and level of physical fitness. MD's staff also complained that his communications in the office were rude or belittling. Despite taking multiple hours of Board ordered CME on professional boundaries and sexual misconduct, MD did not change his behavior or the way he communicates with female patients. Recommendations from an Acumen assessment advised that MD avoid physical contact with patients, unless medically necessary, and to cease all forms of banter	One year suspension stayed with conditions; 60 days active suspension 11/1/26 - 12/31/2026

		and provocative humor in professional interactions.	
MAZUMDER, Sudipta, MD (200601321) Charlotte, NC	6/25/2026	In 2023, MD was convicted on six counts of making False Statements Relating to Health Care Matters. In June 2026, MD was sentenced to five years probation with eight months of home confinement. MD has not practiced clinically since June 2022.	Indefinite Suspension
LIMITATIONS/CONDITIONS			
DAVIDSON, Larry Steve, MD (009400460) Florence, SC	5/18/2026	MD has not practiced in NC since 2010 but remains actively licensed in South Carolina, where he practices. A 2018 Consent Order required MD to abstain from alcohol under monitoring contracts with NCPHP and SCRPP. He violated that order by consuming alcohol in 2020 and 2021, which led him to inactivate his NC license in 2021 and receive a Public Letter of Concern. Since signing a new SCRPP contract, MD has remained compliant. In 2024, he also entered into a concurrent out-of-state monitoring contract with NCPHP, which supports his return to practice.	License reinstated subject to terms and conditions
KOURI, Elyse Rae, PA-C (001012422) Winston Salem, NC	6/18/2026	In 2024, PA was charged with DWI. She had a Board ordered assessment and signed a two-year monitoring contract with NCPHP that required her to abstain from alcohol and other mood-altering substances. In 2025, PA reported to NCPHP that she drank alcohol, which violated her monitoring	Non-Disciplinary Consent Order; PA shall comply with all terms & conditions of her NCPHP monitoring contract

		contract. PA underwent a comprehensive assessment and treatment at a residential facility. Upon discharge, PA was deemed safe to return to work on the condition that she adhere to an aftercare plan and monitoring designed to support abstinence, emotional stability, and patient safety. In January 2026, PA signed a five-year monitoring contract with NCPHP.	
LECHE, Blake Christian, MD (202603794) Easley, SC	6/29/2026	MD failed to disclose on his NC license application to this Board that he voluntarily surrendered his DEA registration. In 2018 MD's SC medical license was temporarily suspended then reinstated and restricted from prescribing, administering, ordering, dispensing, or using any controlled substance in Schedules II through IV. MD had provided blank pre-signed prescriptions to his then wife, a PA, who used the blank pre-signed sheets for prescriptions, including opioids, for patients while he was out of the office. In 2020 MD was reprimanded and fined by the SC Board, restricted from supervising any practitioner and prescribing any scheduled narcotics.	License issued subject to terms and conditions
LEWIS, Catherine Renee, MD (202101788) Pittsburgh, PA	6/11/2026	MD last practiced general surgery in Virginia and has not practiced since 2023. In 2021, the New Mexico Medical Board denied licensure due to concerns of MD's competence in general	Restricted to the practice of non-surgical critical care medicine

		surgery. In 2022, the Missouri Medical Board denied MD's application based on the New Mexico Board's licensure denial. The Georgia and Tennessee Boards also restricted MD's license to the practice of nonsurgical critical care medicine.	
REPRIMANDS			
BELLAMY, Brandi, PA-C (001016710) Fayetteville, NC	6/22/2026	PA twice took but did not pass, the Physician Assistant National Certifying Examination (PANCE). PA submitted a request for an exemption from the 90-day retake requirement due to personal medical issues and submitted a doctor's note from an urgent care practice signed by a PA. The NCCPA discovered that the letter was not valid and was not written by the PA whose name appeared on the document. Facing disciplinary proceedings PA falsely claimed that her email was hacked, denied a documented conversation with NCCPA staff and denied requesting an exemption and sending fraudulent documentation. NCCPA denied the waiver request. PA later admitted that she had falsified her claim of a medical issue, fraudulently provided medical documentation of a fictitious illness, and lied about her email being hacked. NCCPA issued a non-permanent revocation of PA's eligibility for certification. Eligibility for certification was later re-	Reprimand; PA license issued subject to terms and conditions

		established, PA retook and passed the PANCE, and was certified by the NCCPA. The Board ordered PA to be examined by NCPHP. PA has signed a two-year monitoring contract with NCPHP.	
CAPRISE, Peter Andrew, Jr. MD (200000024) Lynchburg, VA	6/18/2026	MD misinterpreted the MRI of a female patient who experienced ongoing right posterior knee pain. MD surmised that one of the nodules described by the radiologist who reviewed patient's MRI was a Baker's cyst. However, the largest nodule seen on the MRI did not contain a fluid signal, thus indicating it was solid. MD should have discerned the difference between a Baker's cyst versus a nodule without fluid signal at the site where a Baker's cyst is normally found. In addition, MD should have sent a tissue specimen from the synovectomy to pathology. These omissions resulted in a delay in diagnosis and treatment of Patient's sarcoma.	Reprimand
COLLINS, Roger Stewart, MD (200500353) Cary, NC	6/12/2026	Patient underwent laser liposuction with abdominal excision. A #10 Blake drain was placed to decrease risk of seroma formation postoperatively. A nurse at MD's practice with prior drain removal experience removed the drain. Months later a general surgeon removed a segment of drain 36 centimeters in length that had been retained following the surgery performed by MD. While	Reprimand; MD shall complete Category I CME on documentation

		MD did not perform the drain removal, as the supervising physician he is responsible for the actions and omissions of his clinical staff. MD failed to ensure that his staff was educated on the importance of thoroughly documenting drain removal, including confirmation of complete removal and any indications of broken tubing.	
DESSIE, Binyam Ayele, MD (202501216) South Hill, VA	5/8/2026	In 2025 the Virginia Board reprimanded MD, placed his medical license on probation, fined, and ordered him to complete 15 hours CME on professional boundaries based on MD's inappropriate communications toward the mothers of two minor patients. The Virginia Board concluded that MD failed to maintain appropriate practitioner/patient boundaries, and he engaged in sexual contact with a key third party that may reasonably be interpreted as intended for his sexual arousal or gratification.	Reprimand
ELLIS, Jonathan Edward, MD (202101887) Waynesville, OH	6/24/2026	In March 2026, the New Mexico Medical Board reprimanded and fined MD based on allegations that he failed to provide appropriate follow-up care or referrals to a patient with elevated intraocular pressure findings and who had undergone telemedicine eye examinations at an eye clinic where MD was remotely providing care.	Reprimand

GUPTA, Aneeta Jain, MD (200101210) Hendersonville, NC	5/26/2026	MD saw a 50-year-old male patient at her outpatient neurology clinic who was experiencing severe headaches with neck pain, nausea, and vomiting for approximately three weeks. MD diagnosed Patient with migraines, consistent with muscle tension headaches. When Patient was brought to the ER, he was diagnosed with meningitis and admitted for antibiotic therapy. Patient further decompensated and was eventually transferred to hospice care where he died. MD did not recognize Patient's presentation and symptoms which indicated that his headaches were the symptom of another disease process, did not perform a proper neurological examination and did not immediately refer Patient to an emergency department for admission, urgent workup, and empiric antibiotics.	Reprimand; MD shall complete nine hours Category I CME
HILLMAN, Vincent Francis, MD (200401514) Charlotte, NC	6/9/2026	In 2025 MD reported to NCMB that he received a Notice to Cease and Desist the unlicensed and unlawful practice of medicine from the Mississippi Medical Board. Their investigation followed a complaint from a Mississippi provider who discovered that one of his patients was obtaining hydromorphone monthly from MD who is not currently licensed, nor has he ever been licensed, in Mississippi. MD would see six patients who reside in	Reprimand

		Mississippi, in Charlotte, NC, then send prescriptions to their respective pharmacies in Mississippi.	
IMAM, Naiyer, MD (200500428) Roanoke, VA	5/26/2026	MD interpreted the right knee x-ray of a 21-year-old male with a prior history of proximal tibia fracture and reported no evidence of acute fracture or dislocation, no joint effusion, and mild soft tissue calcification in the proximal medial thigh. Subsequent evaluation revealed a diagnosis of osteosarcoma, which ultimately required chemotherapy and amputation. The Board's reviewing expert compared the x-ray films, noting progression of the soft tissue tumor, which had increased in size and in circumferential calcification and criticized MD's failure to recognize a primary bone tumor and his mischaracterization of a calcified soft tissue mass. MD was ordered for a comprehensive competency assessment.	Reprimand; MD shall complete an Educational Intervention Plan
PIERCE, Charles Grainger, MD (000022162) Ahoskie, NC	5/22/2026	In December 2024, MD retired and closed his practice. Patients were given six months to obtain their medical records. After six months, the paper records and those hard-copy records that were converted to the electronic medical record (EMR) system were destroyed. Records that were strictly electronic were maintained for an additional four months by MD's EMR	Reprimand

		vendor. The medical records of minor patients should be maintained until the age of eighteen plus seven years. Immunization records should be maintained permanently. By destroying the medical records in six months to a year, MD violated his ethical obligation to preserve these records.	
RAU, Nikhiel Bhasker, MD (201800480) Statesville, NC	6/25/2026	MD's care of a 61-year-old female who was referred for evaluation of persistent iron deficiency anemia fell below the standard of care. Patient's medical history included GERD, a prior procedure to create a direct connection between the stomach and the mid-small intestine (Roux-en-Y gastrojejunostomy), and a significant upper gastrointestinal bleed. During an upper endoscopy, MD identified severe abnormal narrowing at the surgical GJ anastomosis and elected to perform a balloon dilation resulting in a perforation at the GJ anastomosis. The Board's reviewing expert criticized MD for performing therapeutic dilation in an asymptomatic patient with high-risk anatomy due to prior Roux-en-Y gastrojejunostomy. Additionally, the reviewing expert noted MD's failure to provide procedure-specific informed consent.	Reprimand; MD shall review guidelines on informed consent for GI endoscopic procedures
SINGLEY, Patrick Marcus, MD (202402728) Fort Bragg, NC	5/27/2026	In May 2025 MD was arrested for DWI, Speeding, and Reckless Driving to	Reprimand

		Endanger. The Board ordered MD for examination by NCPHP to assess his fitness to practice medicine with reasonable skill and safety. MD submitted a urine drug screen that was positive for alcohol. NCPHP recommended MD undergo a residential substance use disorder evaluation and did not support his safety to practice medicine at that time. MD scheduled but did not attend the examination. In November 2025, MD was diagnosed with alcohol use disorder, severe, major depressive disorder, recurrent, moderate, and unspecified anxiety disorder and was deemed unsafe to practice medicine. MD completed residential treatment and signed a five-year monitoring contract with NCPHP. MD has not practiced medicine since July 2025.	
SOBOLEWSKI, Craig Joseph, MD (200301174) Morrisville, NC	6/11/2026	MD's diagnosis of ectopic pregnancy in a 29-year-old female was made prematurely without adequate confirmation. The ultrasound findings reviewed by MD suggested a potential intrauterine gestational sac, although not definitive, should have prompted further observation rather than immediate administration of methotrexate.	Reprimand
SZABO, James Joseph, MD (000036839) High Point, NC	6/10/2026	MD failed to prioritize and treat an urgent, potentially	Reprimand; MD shall complete 26 hours of

		life-threatening condition in a returning patient on whom he performed an excision of epidermal inclusion cyst located on the left cheek. MD did not evaluate the patient for hemodynamic and airway stability, open and evacuate the hematoma or otherwise control active bleeding, nor coordinate appropriate and timely transfer of care. MD failed to document the critical discussions instructing Patient to discontinue an anticoagulant prior to procedure, and the medical record documentation did not include the indication for Patient's use of anticoagulation therapy.	Category I CME
VAN DALEN, Robert Warren, MD (000026880) Graham, NC	5/20/2026	MD retired from the practice of obstetrics and gynecology in 2017. His medical license has remained active since that time. MD kept a prescription pad from his former practice and used it to write prescriptions to himself and to family members for many years after his retirement. MD admitted to writing the prescriptions for antibiotics, topical steroid cream, glaucoma eye drops, estradiol cream, birth control, and inhalers.. It is contrary to medical ethics for licensees to treat and manage chronic conditions, including providing ongoing prescriptions for non-controlled medications, for themselves, their immediate family members, or those	Reprimand

		with whom they have a significant emotional bond.	
WATSON, Stanley Rudolph, MD (000038490) Four Oaks, NC	5/20/2026	In 2023, the Board requested that MD obtain extensive CME after concerns regarding his controlled substance prescribing practices. MD completed 44 CME hours on controlled substance prescribing and medical record-keeping in 2024. In February 2025, the Board conducted a follow-up review of the North Carolina Controlled Substances Reporting System (NCCSRS). The Board found that MD continued to exercise poor pharmacovigilance and record-keeping.	Reprimand; Required to obtain practice monitor
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
NONE			
PUBLIC LETTERS OF CONCERN			
AVERY, Kirsten Hill, MD (009900757) Raleigh, NC	5/12/2026	The Board is concerned about MD's care of a 36-year-old female. MD prescribed opioids and increased Patient's dose by switching hydrocodone to oxymorphone. She was also prescribed anticonvulsant and muscle relaxant, while other providers prescribed benzodiazepines and a central nervous system stimulant. The patient was later found dead, and autopsy determined the cause was combined drug toxicity. Although MD documented diagnoses consistent with her history, MD failed to include opioid dependence, opioid	Public Letter of Concern

		addiction, and family history of alcoholism, all of which reflected high overdose risk.	
BELL, Stephen Wayne, PA-C (000102973) Terre Haute, IN	6/2/2026	The Board is concerned about PA's care of a 45-year-old female who presented to the emergency department with right foot pain radiating into the calf and numbness/tingling for two days without injury. Triage documented a cool, pale foot with palpable pulses and capillary refill under 3 seconds. PA diagnosed foot pain and discharged Patient with pain medication. Patient was later found to have a right leg arterial occlusion requiring below-knee amputation. The Board's expert opined that the triage findings suggested acute arterial occlusion causing ischemia, a vascular emergency, and noted no documentation of the foot's neurovascular status or differential diagnosis reflecting consideration of a limb-threatening emergency.	Public Letter of Concern
BROWN, Andrew Nathan, MD (202603592) Johnson City, TN	6/18/2026	The Board is concerned that in November 2021, MD was reprimanded by the Tennessee Medical Board and required to complete intensive CME. The Tennessee Board's action concerned allegations that as supervising physician for a NP practicing pain management, MD cosigned ten patient records indicating that he had reviewed the controlled substance prescribing	Public Letter of Concern

		documented in the medical record when, in fact, he had not. As a result of the Tennessee Board's action, the Virginia Board of Medicine took reciprocal action and issued MD a reprimand via Consent Order.	
CLARKE, Delphia Mathilda, MD (200000199) Minneapolis, MN	5/22/2026	The Board is concerned about MD's interpretation of a non-contrast CT scan of a 55-year-old female, who had right flank pain, nausea, vomiting, and decreased urination and identified a 4 mm kidney stone stuck in the lower part of the right tube that drains urine from the kidney to the bladder, causing swelling of the kidney. Approximately eight months later, an ultrasound revealed growths on both sides of the uterus and moderate free fluid. Ovarian carcinoma involving both ovaries with small growths on the lining of the abdomen and build-up of fluid in the belly were found. The Board's reviewing expert determined that a featureless, minimally heterogeneous mass was present in the right lower quadrant and that this finding was not identified or addressed in MD's report.	Public Letter of Concern
CONRAD, Teresa Lynn, MD (201501543)	5/4/2026	MD was a member of the care team that managed a lengthy and complicated labor and delivery. MD's primary role was supervision of residents and other providers. The child was ultimately delivered by	Public Letter of Concern

		cesarean section by another physician after MD's shift ended. The child required resuscitation at birth and immediate transfer to the neonatal intensive care unit at another facility for possible hypoxic ischemic encephalopathy and died approximately one week later. In May 2024, the Board requested a written explanation of MD's care. MD did not respond to the Board's inquiry until July 2024, when she requested an additional 30-days to provide a written response. Despite being allowed 30 additional days to respond, it was not until July 2025, that MD finally submitted a written explanation of the patient care.	
BARNETT, Jeremy David, MD (202603750) Kingston, NY	6/26/2026	The Board is concerned that in 2022 the New York Medical Board reprimanded, fined and required MD to complete CME on the topics of documentation, communication, and ethics based on two documentation-related issues occurring in 2018. MD received reciprocal discipline by the Illinois and Ohio Medical Boards. MD was named as one of several defendants in a 2023 malpractice settlement for care provided in 2018 in New York. The claim alleged negligent treatment in thrombolysis of a clot in the patient's small mesenteric artery with complications that resulted in an ischemic bowel and death of the	Public Letter of Concern

		patient.	
HOOD, Kyon Amiel, MD (201402233) Lewisville, TX	5/26/2026	The Board is concerned about a complaint that a patient paid for treatment that was not provided due to the abrupt closure of a facility where MD was the medical director. A review of Patient's records indicates that MD was not appropriately involved in the screening of this patient for treatment and that there was a lack of appropriate documentation. As the medical director and supervisor, MD has a duty to oversee patient care.	Public Letter of Concern
JOSHI, Anand Maheshkumar, MD (201800141) Wilmington, NC	5/26/2026	The Board is concerned that a NP filed a complaint with the DEA regarding allegations of medication substitution occurring at her workplace. The NP treated and prescribed Sublocade to a patient that was to be administered at the clinic. Staff were unable to locate the patient's prescribed injection. The clinic's owner, who is not a licensed physician, authorized a medical assistant to inject Patient with a Sublocade injection that was prescribed for another patient. The NP was informed and was asked to ensure another Sublocade injection was prescribed under Patient's name and to be administered to the other patient. The NP refused to do so, and immediately informed MD of the incident and her objection to it. MD was the supervising physician of the	Public Letter of Concern

		APPs at this practice. While MD maintained collaborative practice agreements with the APPs, he did not hold formal Quality Improvement meetings or document having meetings. The Board requests MD familiarize himself with the regulatory requirements of supervising physician assistants found in 21 NCAC32S.0213 and nurse practitioners 21NCAC 32M.0110. The investigation also raised issues concerning the corporate practice of medicine at the practice. The Board strongly recommends that MD review the position statement entitled, Corporate Practice of Medicine and Referral Fees and Fee-splitting.	
KIM, Gregory Yung Suk, MD (201502368) Elizabeth City, NC	6/15/2026	The Board is concerned that in 2025 the Virginia Board issued an Advisory letter to MD after investigating a complaint regarding a 2022 wrong-site surgery. MD performed a surgical excision of a cyst and sinus tract of the lower back without complication. Post-operatively the error was discovered. The Board's reviewing expert opined that the medical record documented the cyst in an atypical location for a pilonidal cyst, indicating that the cyst was unlikely to be a pilonidal cyst. However, the term “pilonidal” was continually used throughout the documentation, which led to confusion for MD and	Public Letter of Concern

		his staff on the day of surgery.	
LOPEZ-STRATTON, Anna E., MD (009700405) Clyde, NC	5/8/2026	The Board remains concerned about repeated communication deficiencies in MD's practice. In this complaint, a 43-year-old patient's CT scan for abdominal pain showed a potential superior mesenteric artery dissection. MD did not personally communicate the abnormal findings; instead, a Certified Medical Assistant under MD's supervision relayed the findings. MD later acknowledged that she mistakenly believed she had already contacted the patient. The Board remains concerned about MD's repeated failures to communicate with patients appropriately and in a timely manner.	Public Letter of Concern
MARTIN, Jonathan Gilbert, MD (201402111) Durham, NC	6/8/2026	The Board is concerned about MD's care of an 81-year-old male who was admitted for a robot-assisted right colectomy. MD and another physician examined Patient, reviewed imaging and discussed the procedure which was intended to be performed on Patient's right side. MD and the other physician performed angiograms and embolizations on the left side instead of the originally intended right side.	Public Letter of Concern
MILL, Michael Robert, MD (000032795)	5/28/2026	The Board is concerned about MD's care of a 2-year-old child born with hypoplastic left heart syndrome scheduled to	Public Letter of Concern

		undergo a Fontan procedure, aortic arch repair, and left pulmonary arterioplasty. Preoperatively, MD documented cough with congestion and ordered tests that did not suggest infection; however, MD did not note the respiratory symptoms in the history and physical, and the elective high-risk surgery proceeded. Postoperatively, Patient developed fever, respiratory distress, rhinovirus infection, pneumonia, sepsis, and multi-organ failure, resulting in death. The Board's expert concluded the respiratory symptoms warranted further evaluation and delay of surgery, and that proceeding exposed Patient to increased risk of complications.	
MILLER, Alexander Brian, MD (202201711) Newtonville, MA	6/25/2026	The Board is concerned about MD's care of an 81-year-old male who was admitted for a robot-assisted right colectomy. MD was a resident working with another physician. MD and the physician examined Patient reviewed imaging and discussed the procedure which was intended to be performed on Patient's right side. MD and the other physician performed angiograms and embolizations on the left	Public Letter of Concern

		side instead of the originally intended right side.	
PEREZ-RIVERA, Efrain MD (009401300) Smithfield, NC	6/8/2026	The Board is concerned about MD's care of a 29-year-old patient during the labor and delivery of her child. Patient underwent a vacuum-assisted vaginal delivery during which a shoulder dystocia occurred. The newborn was subsequently diagnosed with a left brachial plexus injury, a subgaleal hematoma, and a skull fracture. Documentation of the efforts to deliver the baby once a shoulder dystocia was diagnosed fell below the minimum standard of care.	Public Letter of Concern: MD agrees to complete continuing medical education on documentation
PRATO, Christopher Allen, MD (200801483) Gastonia, NC	6/26/2026	The Board is concerned that MD performed a knee arthroscopy on a 56-year-old male who was scheduled for arthroscopic surgery on the left knee, but MD mistakenly performed the procedure on the right knee, where a meniscal tear was also identified and repaired. MD recognized that surgery had been performed on the incorrect knee, promptly disclosed the error to Patient and his wife, accepted responsibility, and discussed available options.	Public Letter of Concern
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	5/12/2026	The Board is concerned that in September 2025, a patient's confidential lab results were improperly texted to someone listed only as an emergency contact, without the patient's authorization. MD further acknowledged that this was part of an office	Public Letter of Concern; MD and staff will complete HIPAA training

		practice rather than an isolated error, raising concerns about systemic privacy compliance failures.	
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	5/12/2026	The Board is concerned about MD's care of a 47-year-old male diagnosed with generalized anxiety disorder, palpitations, sleep apnea, cardiac arrhythmia, hypertension, and post-traumatic stress disorder based on patient history, prior records, and home pulse oximetry. MD prescribed Vraylar for depression and clonazepam for anxiety. At follow-up, no vital signs were recorded. MD increased clonazepam and started Lexapro, but the note did not explain the rationale for Lexapro, assess Vraylar's effectiveness or tolerability, or discuss the risks and benefits of increasing a benzodiazepine. After the patient missed two appointments, MD sent a termination letter and provided a 90-day medication supply but did not state that care would continue for 30 days after dismissal or explain how the patient could obtain or transfer medical records. In addition, the documentation failed to follow standard SOAP note conventions.	Public Letter of Concern; MD will complete CME on communication and documentation
UBA, Daniel Chidi, MD (200100099) Fayetteville, NC	6/3/2026	In May 2024, the Board received a complaint that a patient was allegedly sexually assaulted by an APP at MD's practice. The APP has a history of sexual misconduct dating back to 2006. In March 2017, due to	Public Letter of Concern

		the restoration of the APP's license and approval to practice as a Nurse Practitioner he was rehired and MD resumed supervising APP. MD required that the APP have a chaperone present for intimate examinations of female patients, but not for routine examinations. Given MD's general knowledge of the APP's disciplinary history and his prior misconduct, the Board is concerned that MD may have failed to provide adequate supervision to this APP under these specific and exceptional circumstances.	
WAGNER, Elliott Jay, MD (200802087) New York, NY	5/20/2026	The Board is concerned about MD's care of a 13-year-old male who presented with a one-week history of severe, persistent left leg and hip pain, worsened with movement and unresponsive to conservative treatment. MD interpreted radiographic imaging of the left knee and left hip with pelvis and reported no acute bone abnormality. Imaging was repeated at an ED, and showed a slipped capital femoral epiphysis. The Board's reviewing expert determined that the original hip radiographs showed a left slipped capital femoral epiphysis. MD's failure to identify and report this finding on the hip imaging fell below the minimum standard of care.	Public Letter of Concern
WRIGHT-THOMASSON, Debbie Ruth, MD (201001513) Remsen, NY	5/21/2026	The Board is concerned that MD prescribed Diazepam, a	Public Letter of Concern

		Schedule IV controlled substance to her daughter (Person A). Prescription history shows MD prescribed 30 tablets to be compounded into suppositories. The prescription history also revealed that Person A was prescribed the same medication to be taken orally a day earlier by another provider. MD confirmed that she prescribed the controlled substance to Person A due to her experiencing severe, debilitating pain. Board rules prohibit the prescribing of controlled substances for the use of a physician's immediate family, no matter the situation.	
ZUBER, Thomas John, MD (000030266) Cary, NC	5/5/2026	The Board is concerned about MD's care and lack of proper documentation in the case of a 55-year-old male who presented with complaints of exhaustion, thirst and frequent urination. A urinalysis showed symptoms consistent with uncontrolled diabetes. Patient left during the discussion of labs. Four days later patient was admitted to hospital for treatment and diagnosed with diabetic ketoacidosis and new onset diabetes. MD's failure to diagnose Patient's diabetic ketoacidosis and new onset diabetes during his visit and incomplete documentation of a physical exam indicate MD's care of patient may	Public Letter of Concern

		have fallen below the standard of care.	
MISCELLANEOUS ACTIONS			
CRUZ, Andrew Stephen, MD (2022-02823) Charlotte, NC	6/15/2026	In October 2020, MD completed a residential treatment program due to concerns related to his consumption of alcohol. MD entered into a three-year monitoring contract with the Massachusetts Physician Health Services (MAPHS) and agreed to abstain from ingesting alcohol. MD signed an out-of-state monitoring contract in 2022 with NCPHP to run concurrently with the MAPHS monitoring contract. In June 2023, MD admitted to MAPHS that he consumed alcohol over the course of two days. MD inactivated his NC medical license while under investigation in April 2024. MD has remained in compliance with his MAPHS and NCPHP contracts since 2023. NCPHP supports MD's return to medical practice.	License Reinstated
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
MEARES, Charles John Devenish, MD (202602530) Maroubra	5/1/2026	The Board issued MD a Special Purpose License to practice medicine in NC effective May 15, 2026, thru May 14,2027. MD agrees to not practice medicine outside the limitations set forth in the Agreement.	Special Purpose License Agreement

COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			