Adverse Actions Report May-June 2025

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			
CANCHOLA, Daniel Ramiro (201100164) Dallas, TX	5/7/2025	MD's felony conviction for Conspiracy to Commit Health Care Fraud and Wire Fraud	Revocation of NC medical license
HOWER, Erin Lynn, MD, (201701502) Suwanee, GA	5/5/2025	MD's felony conviction for False Statement	Revocation of NC medical license
SUSPENSIONS			
ADIX, Michael Lee, MD (009401112) Holiday, FL	6/27/2025	MD was convicted on four counts of Fraud and False Statements. MD was charged with underreporting income he earned as an emergency room physician to the IRS. MD is currently incarcerated with a scheduled release date of September 2027.	Indefinite suspension of medical license
STONE, Shane Frank, MD (201301885) Denton, TX	5/5/2025	MD was reprimanded by the Texas Medical Board, which found that he exchanged sexually explicit photos, videos, and suggestive text messages with a patient. MD failed to adequately document the patient's treatment plan for ADHD and failed to monitor the patient's prescription medications while prescribing controlled substances. The Texas Board Order required that MD	Suspension stayed after 90 days with terms and conditions

		have a chaperone present for in person and telehealth patient interactions, pass the Texas jurisprudence exam, complete professional boundaries courses and complete courses in ethics, risk management, record keeping and prescribing of controlled substances.	
LIMITATIONS/CONDITIONS			
LEE-WOOD, Russell Stephen, MD (202401095) Barnesville, OH	6/30/2025	The Ohio Medical Board, which found that MD failed to adequately supervise a PA, who did not have prescriptive authority but nonetheless prescribed Schedule II controlled substances to 11 patients. The Ohio Consent Agreement required that MD be suspended for 180 days, prohibited him from supervising APPs and pay a fine as well as complete CME.	Suspension stayed; Shall not serve as supervising physician for any APP
REPRIMANDS			
CILIBERTI, Devin Mark, MD (200100221) Hurricane, WV	5/6/2025	A West Virginia Board Consent Order reprimanded MD and required him to pay a fine. The Order was based on unprofessional conduct. The WV Board opened an investigation into MD's care and treatment of three OB/GYN patients under his care. The investigation revealed that the hospital at	Reprimand

		which he was employed received complaints and concerns regarding unprofessional and disrespectful behavior by him towards coworkers and patients, including his use of profanity in front of patients.	
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
NONE			
PUBLIC LETTERS OF CONCERN			
ALLEN, Dana Mark, MD (202000399) Ocala, FL	5/7/2025	The Board is concerned about MD's care of a 59-year-old male who presented to the emergency department with complaints of right-sided weakness, headache and difficulty walking. Given the patient's history of deep vein thrombosis with lower extremity stent and ongoing blood thinner therapy, a CT of the head and a CTA of the neck/carotid arteries were performed. MD interpreted the CTA as negative, reporting the vertebral arteries patent and codominant, with no significant stenosis or occlusion identified. The patient was subsequently monitored and discharged the next day with outpatient neurology follow-up. Days later the patient went to another emergency room with a sudden recurrence of symptoms. He underwent further imaging which included a brain MRI as well	Public Letter of Concern

		as repeat head CT and CTA. The patient was diagnosed with a right medullary infarction, resulting in persistent neurological defects. The Board's independent medical expert found that MD's interpretation of the CT angiogram of Patient's head and neck did not meet the standard of care. The correct diagnosis of a severely stenotic or occluded distal right vertebral artery was evident in the imaging studies MD interpreted.	
BROWN, Matthew Thomas, MD (202501647) Anderson, SC	5/30/2025	The Board is concerned that MD's care of an 80-year-old female patient may have failed to conform to the standard of care. MD performed a lumbar decompression procedure on the patient, who had consented to undergo surgical decompression at the L3-L4 level. Postoperatively, the patient continued to experience pain, and a CT scan revealed that the lumbar decompression had inadvertently been performed at the L2-L3 level. Although MD indicated that intraoperative findings and lack of fluoroscopy images contributed to his belief that he had operated at the correct level, the procedure was ultimately conducted at the wrong spinal level. The patient underwent a subsequent decompression	License issued with Public Letter of Concern

		procedure at the L3-L4 level with another surgeon. The patient did not sustain any permanent neurological injury as a result of the wrong site-level surgery.	
BURNETTE, JP, MD (000020111) Wilson, NC	6/6/2025	MD and his former practice partner sold their medical practice to a chiropractor knowing the chiropractor was not a licensee of this Board. MD remained and served as the practice's medical director and supervising physician for the APPs in a contract employee position. Under NC law, a business entity that engages in the practice of medicine must be owned by licensees of this Board. Unless an exception applies, lay persons who own and operate medical practices are engaged in the unlawful corporate practice of medicine. When a licensee of this Board assists lay owners of a medical practice in the unlawful corporate practice of medicine, they are aiding and abetting this unlawful practice.	Public Letter of Concern
BYERLY, Faera Ledford, MD (200500169) Greensboro, NC	6/26/2025	The Board is concerned about MD's treatment and care of a 21-year-old male who was admitted to an emergency department as a trauma patient after sustaining several gunshot wounds and incurring multiple injuries. MD began to care for the patient several days later. The patient became increasingly tachycardic with labored	Public Letter of Concern; shall complete CME on identification and treatment of Small Bowel Obstruction

		breathing, pale skin, and reported lightheadedness and severe abdominal pain with notable abdominal distention. A Rapid Response Team nurse notified MD of the patient's worsening presentation. MD ordered a cessation of diet and medications to address the nausea and vomiting occurring throughout the night but did not reassess the patient. Shortly after MD's shift ended, the patient became critically unstable with progressive deterioration, ultimately resulting in cardiac arrest and death. The Board's reviewing expert criticized MD's failure to order placement of a nasogastric tube.	
DAHIYA, Ravinder, MD (202502059) Rockville, MD	6/23/2025	MD was reprimanded by the Maryland Board and fined $20,000 based on their determination that in 2018 a patient, at an aesthetic practice where MD was the medical director, received substandard care when expired dermal filler was used during a procedure. The Maryland Board found that as the medical director MD was responsible for the appropriate and safe administration of injectables.	License issued with Public Letter of Concern
DEDMON, Matthew Morris, MD (201800496) Chapel Hill, NC	6/30/2025	The Board is concerned that MD's care of a three-year-old female failed to conform to the standard of care. The patient presented for evaluation and treatment of	Public Letter of Concern

		bilateral sensorineural hearing loss. The Board's reviewing expert opined that while MD accurately diagnosed the patient, he failed to obtain and adequately review the pre-operative CT and MRI scans that were performed at an outside institution and relied upon written reports from the radiologists, as well as his personal review of the scans on a cell phone. Failure to do so resulted in the inability to diagnose the right mastoid anatomic anomaly that placed the right facial nerve in jeopardy during the cochlear implant procedure and the anatomic temporal bone anomaly.	
HOOD, Bold Robin, III, MD (202501843) Jacksonville, FL	6/12/2025	The Board is concerned about several non-disclosures of information on MD's license application. First, he failed to disclose an investigation by the United States Navy undertaken while he served as a military physician. MD also failed to disclose three malpractice cases in which he was named as a defendant, and which resulted in settlements made on his behalf. All three cases involved allegations that MD failed to meet the applicable standards of care in his treatment of minor patients.	License issued with Public Letter of Concern and $1,000 Fine
KILPATRICK, Robert, MD (2 02501507) Jupiter, FL	5/20/2025	Multiple state medical boards have taken public action against MD's medical licenses based on action taken by the Nevada State Board of Medical	License issued with Public Letter of Concern

		Examiners. The Nevada Board alleged MD "failed to seek consultation in a doubtful or difficult case." The basis of the Nevada Board's action was an incident occurring when a 14-year-old female presented to the emergency department with complaints of abdominal pain, mild vaginal bleeding, and a fever after giving full-term birth five days prior. MD examined her and consulted with an obstetrician via telephone, however a bedside consultation never occurred. The patient was discharged with instructions to follow up with her obstetrician within two days. Two days later, she was found unresponsive, admitted into the pediatric intensive care unit, and died the following day.	
MANFREDI, Brenda Laurie, MD (202000427) Greensboro, NC	6/30/2025	The California Medical Board accepted the surrender of MD's license. The California Board alleged repeated negligent acts, excessive prescribing, failure to maintain adequate and accurate medical records, furnishing drugs to an addict, and violation of federal/state drug statutes regarding the care of three patients. MD was provided an option to settle the California investigation. This resolution would have required certain action of MD within the State of California, which was not possible once she relocated	Public Letter of Concern

		to NC. Therefore, she elected to voluntarily surrender her California medical license. MD completed several courses related to opioid prescribing since the events leading to her license surrender in California.	
MORRISON, Daniel Rhodes, MD (202301609) Charlotte, NC	6/18/2025	A Board investigation revealed that on April 4, 2024, MD and other co-workers went to a bar to socialize prior to an office meeting at 6:00 p.m. MD admitted that at the bar he consumed two alcoholic beverages before returning to the office for the staff meeting with numerous other physicians who were not on duty. The Board found that MD was on call from 5:00 p.m. to 8:00 a.m. that same day. MD answered phone calls and texts regarding medical matters while on call. The Board notes that after the event, MD was counseled by the practice president on the practice's policy of no alcohol consumption while on call and that MD was not aware of the practice's policy prior to the counseling.	Public Letter of Concern
POWERS, Jeremiah David, MD (001009738) Henderson, NC	5/9/2025	In 2022, PA provided medical care to a 70-year-old male with comorbidities including obesity, COPD, and hypertension. PA saw the patient on multiple occasions treating for lower left extremity cellulitis, venous stasis ulcer, edema	Public Letter of Concern; PA shall complete CME and have patient charts co-signed by supervisor for 6 months

		in both lower extremities, and other chronic health conditions. Despite persistent non-healing wounds, PA did not order laboratory testing, continued to administer intramuscular ceftriaxone weekly or bi-weekly, and prescribed oral and topical steroids. At the patient's last visit with PA, he had developed other health issues and overall decline in status. At no time did PA conduct laboratory or other testing to assess the patient given the symptoms presented. The patient was admitted to the hospital the day after his last visit with PA. He died three days later from complications related in part to sepsis secondary to cellulitis, myocardial infarction, and associated ketoacidosis. The Board's independent reviewing expert found that a referral to a wound-care specialist should have been made if PA did not have the training or experience in wound management.	
TSAHAKIS, James Michael, MD (201901016) Charlotte, NC	6/23/2025	The Board is concerned that MD's care of a 26-year-old woman may have fallen below the standard of care The patient presented with complaints of headache, nausea, earache, and light sensitivity at the ED where MD was the attending. MD documented that the patient was well appearing, without meningismus, and she had a normal neuro	Public Letter of Concern

		exam. The patient received IV fluids and medication for her headache. MD discussed her ECG with cardiology, who advised observation if she had persistent severe tachycardia. The patient reported feeling better and was discharged home with a diagnosis of acute viral syndrome. The patient was admitted to the hospital the next day and diagnosed with bacterial meningitis and cerebral edema and passed away two days later. The Board's reviewing expert opined that MD's failure to meet the standard of care was the result of a combination of factors, including MD's premature exclusion of bacterial meningitis despite five days of headache, fever, photopia, nausea, leukocytosis, and systemic inflammatory signs, and the fact that he decided to forego further observation which may have allowed the opportunity to reconsider meningitis and/or bacteremia as potential diagnoses.	
VU, Khanh Tuan, MD (000036447) Henderson, NC	5/7/2025	MD served as the primary care physician to two family members who lived at his residence. On three occasions, MD prescribed an opioid cough suppressant to these family members in violation of NC law and Board rules. In 2022, MD supervised an APP who provided medical care to a 70-year-old male with	Public Letter of Concern with Terms and Conditions

		comorbidities including obesity, COPD, and hypertension. The APP saw the patient multiple times treating for lower left extremity cellulitis, venous stasis ulcer, edema in both lower extremities, and other chronic health conditions. Despite persistent non-healing wounds, the APP did not order laboratory testing, continued to administer intramuscular ceftriaxone, and prescribed oral and topical steroids. At the patient's last visit with the APP, he had developed other health issues and overall decline in status. The Board's independent reviewing expert found that the APP's care of the patient may have fallen below the standard of care. A referral to a wound-care specialist should have been made if APP did not have the training or experience in wound management. As the APP's supervising physician, MD maintained the ultimate responsibility to ensure that the patient was provided the highest quality of care.	
MISCELLANEOUS ACTIONS			
NONE			
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			

WHITE, Diane Carol, MD (009401507) Fayetteville, NC	6/26/2025	As a result of MD inactivating her medical license while under investigation effective June 11, 2025, the Board hereby Dismisses Without Prejudice the Amended Notice of Charges and Allegations and Amended Notice of Hearing. If MD later seeks reinstatement of her medical license, she must make an application for reinstatement.	Order Dismissing Charges Without Prejudice