Adverse Actions Report November-December 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			
NONE			
SUSPENSIONS			
FERREE, Charles Elliot, MD (000027175) Charlotte, NC	11/5/2025	MD has a history of alcohol use disorder dating back to 2019, when his employer referred him to NCPHP where a comprehensive evaluation was recommended to ascertain the extent of his alcohol use. MD also participated in a residential treatment program and was monitored by NCPHP upon completion of treatment. Between 2021 and 2024 MD tested positive for and admitted to consuming alcohol. In April 2025, MD completed residential treatment for alcohol use disorder for a third time and signed a third five-year monitoring contract with NCPHP. Four months later, MD again consumed alcohol in violation of that contract. In August 2025, MD voluntarily surrendered his license.	Indefinite Suspension
FUSCO, Lawrence John, MD (009701362) Browns Summit, NC	11/24/2025	MD came to the attention of the Board based on a report from the NC Department of Health and Human Services (DHHS) Safe Opioid Prescribing Initiative. He was identified as being among the top 2% of prescribers of opioids. DHHS previously reported MD in 2017, 2020, and 2024. The Board required MD to take comprehensive CME courses	Indefinite suspension; MD shall not apply for reinstatement of his medical license for at least 2 years

		on opioid prescribing, which MD completed but the attempts at remediation failed. In the cases of five patients MD treated for chronic pain and other health conditions his prescribing and care fell below minimum standards in that he failed to confirm medical diagnoses to support the use of controlled substances and failed to document physical examination findings. He did not perform imaging or diagnostic testing nor order and review laboratory data necessary to support or monitor the prescribed treatment plans.	
LIMITATIONS/CONDITIONS			
NONE			
REPRIMANDS			
ADAMS, Tiffanie Lauren, PA-C (001003714) Charlotte, NC	12/08/2025	The Board received an anonymous complaint alleging PA wrote prescriptions for herself using patients' names. An investigation determined there was no evidence of PA self-prescribing. A North Carolina Controlled Substance Reporting System report revealed that PA prescribed a controlled substance to treat family member's attention deficit/hyperactivity disorder. PA also prescribed non-controlled substance medications to other family members. PA failed to maintain adequate medical records documenting her care and treatment of family members.	Reprimand; PA shall successfully complete the Professional/Problem-Based Ethics course focused on insight, accountability, and ethical decision making
ARMITAGE, Mark Samuel Thomas, MD (200101001) Wilmington, NC	11/18/2025	In a 2018 Consent Order MD was reprimanded, required to surrender his DEA privileges, restricted from prescribing any controlled substances, and required to successfully complete the Professional/Problem-Based Ethics course. Prior to requesting reinstatement from	Reprimand; $5,000 fine; Prohibited from prescribing controlled substances

		the Board, MD was required to provide evidence that he completed Category I CME on prescribing controlled substances. In 2020, the Board relieved MD's restriction of prescribing controlled substances on the condition that he participate in an opioid management program, which MD did not. DEA privileges were restored in 2023 and MD resumed prescribing non-opioid controlled substances. By prescribing controlled substances prior to completion of an opioid management program, MD violated his 2020 Relief Order.	
BALANCE, William Alton, Jr., MD (000031960) Greenville, NC	11/7/2025	MD has a history with the Board including but not limited to a Public Letter of Concern in 2019 based on concerns that he took six months to complete a pathology report. MD also performs private autopsies. MD provided the final autopsy report for Decedent A four and a half years after the death of Decedent A. Decedent B's final autopsy report was provided to the family more than two-years after the death. MD provided the final autopsy report for Decedent C more than two years after being retained and in each case only after the family filed a complaint with the Board. On each occasion, the Board made multiple attempts to contact MD by email and U.S. mail and received no response. The Board's reviewer found that MD failed to conform to the minimum standard of care by delaying the autopsy reports as long as he did.	Reprimand; MD shall no longer perform independent or private autopsies without written permission of the Board
BARTELS, George Thomas, MD (000024108) Cary, NC	11/19/2025	The Board received an anonymous complaint that alleged MD issued prescriptions for phentermine	Reprimand

		in a patient's name without an in-person evaluation. An investigation and review of Patient's medical records revealed that each prescription of phentermine corresponded with a documented patient encounter. MD dispenses medications at his practice. The investigation revealed that all the prescriptions were private pay. MD's patients would pay a monthly flat-rate fee that covered prescriptions for their individualized weight loss treatments and office visits. Board staff informed the DEA and NC Board of Pharmacy (NCBOP) of the complaint. A DEA enforcement agent and an NCBOP investigator conducted an unannounced regulatory inspection of MD's practice, revealing that while MD maintained detailed records above DEA minimum required standards, he needed to re-register with the NCBOP as a dispensing physician. MD's NCBOP dispensing permit expired in April 1993. Despite not holding an active dispensing permit, he continued to dispense medications from April 1993 to present.	
CASERIO, James Joseph, Jr., MD (000025987) Hendersonville, NC	12/3/2025	On multiple dates in October 2023, MD inappropriately accessed Patient's electronic medical record without a medically justifiable reason for doing so and in violation of HIPAA. As a result, MD's hospital medical staff appointment and clinical privileges were suspended for 29 days. MD denies that his access of Patient's records was inappropriate and contends that Patient had never formally transferred her primary care to another provider, and that the	Reprimand; MD shall complete Category I CME on the subject of HIPAA

		hospital and other providers continued to send Patient's records to his office, and thus MD still considered himself as Patient's primary care provider.	
KIELY, James Matthew, MD (2010-02117) Norfolk, VA	12/18/2025	Upon arrival in the emergency department at 11:21 a.m., a patient was exhibiting altered mental status, impaired ability to produce speech, upper extremity weakness, and an inability to gaze to his right. The ED physician ordered a "CT brain attack STROKE Stat." MD reviewed the CT scan and recommended that the symptoms were more consistent with postictal Todd's paralysis and aphasia. MD diagnosed Patient with seizure activity, but did not rule out stroke, and recommended an MRI, EEG, and Keppra 500 mg IV. At 12:31 p.m., MD spoke with another neurologist who recommended a CTA head and neck, with and without contrast. The CTA demonstrated a complete occlusion of the M1 segment of the left middle cerebral artery. The standard of care required MD to recognize that Patient's symptoms were consistent with a possible stroke and to recommend immediate vascular imaging (CTA or MRA) as part of his initial workup. MD's failure to recommend this imaging represented a departure from minimally competent medical practice and created an unacceptable risk of harm to the patient. The Wisconsin Medical Board reprimanded MD for this incident and MD has since obtained substantial CME in cerebrovascular disease, telehealth stroke care, and emergency neurologic life	Reprimand

		support.	
POWERS, Alexander Kendrick, MD (200900882) Kernersville, NC	11/26/2025	MD performed a spinal procedure on a Patient to remove bone and joints at the L1 L2 spinal level to relieve nerve pressure and stabilize the spine with screws. Over the following weeks, Patient reported increasing pain and wound drainage. MD responded primarily by telephone encounters and medication refills. MD prescribed the antibiotic ciprofloxacin without obtaining cultures. Months later, imaging revealed osteomyelitis, infection in the disc space of the lumbar region and loosening of surgical hardware with compression deformity of L1. Patient underwent surgery for removal of hardware. The Board's reviewing expert concluded that while the initial diagnosis was within the standard of care, MD's post-operative treatment and documentation fell significantly below the standard of care. MD's failure to obtain wound cultures, inappropriate overreliance on ciprofloxacin, failure to order diagnostic labs or imaging, and inadequate documentation of clinical evaluations contributed to the delayed recognition of infection and subsequent hardware failure and osteomyelitis.	Reprimand
WEFALD, Franklin Charles, MD (000031685) Smithfield, NC	12/1/2025	The Board received a complaint from a healthcare professional who was providing care to a patient that MD was treating. Complainant noted that MD had been prescribing controlled substance prescriptions for benzodiazepines, opioids, and stimulant medications over the course of three years to Patient	Reprimand; Terms and Conditions established for controlled substances prescribing

		and expressed concern with the level of monitoring being provided to Patient. After reviewing the records of five of MD's patients who were identified as being prescribed opioids and benzodiazepines, the Board's reviewing expert concluded that aspects of MD's prescribing to two patients failed to conform to the standards of care. The reviewer was also critical of MD's inconsistent prescribing of naloxone to patients for whom he was prescribing multiple controlled substances.	
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
PURDY, Laura Ellen, MD (201801536) Miami, FL	11/10/2025		Surrender Acknowledgement
PUBLIC LETTERS OF CONCERN			
CHACHKES, Jacob Shalom, MD (200301342) Wellington, FL	12/2/2025	The Board is concerned that MD's documentation of care provided to Patient may have failed to conform to the standards of care. Patient presented to the emergency department with avulsions and puncture wounds to his upper left thigh believed to be inflicted by a canine officer during his arrest and that had been irrigated and bandaged by EMS. MD's exam of the wounds noted deep, contaminated cuts to the upper leg. Tdap and amoxicillin-clavulanate were administered and eighteen days after MD provided medical treatment to Patient, he returned to the ED with complaints of fever and tachycardia due to cellulitis in his left leg with an open ulcer. The infection did not respond to treatment and Patient underwent an amputation below the knee. The Board's reviewing expert found that	Public Letter of Concern

		MD's documentation did not detail that copious irrigation of the bite wound occurred. There was insufficient documentation of the risk of crush injury and a neurovascular assessment which is required in all extremity bites.	
CORDOVA, Aldo Luigi, MD (202102931) Monroe, NC	11/24/2025	MD was the admitting physician following Patient's syncopal episode. He did not physically examine Patient nor take her history during her admission. Instead, he pre-wrote a medical history and documented a physical examination without ever seeing Patient. In responding to Patient's complaint to the Board, MD said he believed he set his pre-written note as "pending," which he intended to edit after seeing Patient, but the note was mistakenly finalized and entered into Patient's record. Pre-writing histories and physicals in a patient's chart is not an acceptable practice.	Public Letter of Concern
DEY, Holley Manbeck, MD (200401201) Wallingford, CT	11/17/2025	The Board is concerned about MD's care of a Patient with a history of a recent gallbladder removal, who presented to the emergency department with progressively worsening, centralized abdominal pain, accompanied by nausea and vomiting. A physical examination revealed right upper quadrant tenderness. Laboratory results showed an elevated white blood cell count with a left shift. MD's report of a contrast CT scan documented several clinical findings; however, it did not describe or address the appendix. Patient	Public Letter of Concern

		was discharged from the ED with a presumed diagnosis of pain attributable to an ovarian cyst. When Patient returned to the ED with worsening abdominal pain she was diagnosed with a ruptured appendix and intra-abdominal abscesses, requiring treatment. The Board's reviewing expert indicated that a systematic search pattern should have been employed, which would likely have identified early signs of appendicitis.	
HARTENSTINE, Javi Laure, DO (201802629) Las Vegas, NV	11/12/2025	The Board is concerned that DO reviewed the specimen of an endometrial biopsy in her lab and documented a diagnosis of Endometrial Endometroid Adenocarcinoma, Figo Grade I. Based on this, Patient submitted to additional treatment, including a hysterectomy. Following Patient's hysterectomy, additional specimens were obtained and sent to pathology for review. The additional pathology demonstrated there was no cancer. DO later provided an explanation to the Nevada State Board of Osteopathic Medicine stating the results for another patient were incorrectly transcribed into Patient's file and she remedied the error as soon as she was notified.	Public Letter of Concern
KANSAGOR, Adam Troy, DO (201300633) City, ST	11/12/2025	The Board is concerned about DO's care of a patient during a scheduled induction of labor at 40-weeks gestation. Patient expressed a preference for vaginal delivery, despite delivering by Caesarean in her previous pregnancy. The risks of "trial of labor after caesarean" (TOLAC) were explained to Patient and informed consent was obtained. Patient suffered a	Public Letter of Concern

		placental abruption requiring emergent operative vaginal delivery. Delivery was accomplished utilizing vacuum extraction. At the time of delivery, the infant was significantly depressed and required resuscitation. The Board's reviewing expert felt that the interpretation of the fetal heart rate tracings and the response and interventions to those changes may have fallen below standard of care, as well as DO's documentation and supervision of the patient's care. The documentation of the fetal heart rate tracing as well as the delivery note written by one of DO's residents and cosigned by DO, lacked details relating to the operative vaginal delivery.	
LIU, Jason Yeh-Sheng, MD (009900587) Henderson, NV	12/2/2025	The Board is concerned about MD's care of a Patient who reported continual right knee pain and swelling for over a year. Patient was seen multiple times with X-ray imaging being performed. MD interpreted an X-ray of Patient's right femur and knee, reporting no fracture, dislocation, or joint effusion and was read as normal. Patient suffered a pathologic fracture of the right femur while shifting his weight in the shower. An MRI revealed a mass, highly suggestive of osteosarcoma, which was later confirmed via biopsy. Due to disease progression, Patient ultimately underwent chemotherapy followed by a right leg amputation. The radiologic findings concluded that the X-ray image MD read was abnormal and highly suspicious of a malignant bone tumor which should have resulted in further diagnostic imaging and consultation with	Public Letter of Concern

		an orthopedic oncologist. MD has taken steps to remediate by completing the 2025 AIRP Musculoskeletal Imaging Categorical Course.	
PEAK, Edwin Louis, MD (200200978) Clyde, NC	12/3/2025	The Board is concerned that MD's care of a Patient may have failed to conform to the standard of care. MD performed a right hip replacement on a Patient. An x-ray taken immediately after surgery showed that the stem of the hardware was out of position due to a fracture occurring during the surgery. MD was advised of the fracture and the stem being out of position but elected to take no action at that time. At the first post-operative visit with Patient another x-ray was taken that confirmed the misplacement and fracture. As Patient was doing well at that time, MD elected not to perform a revision. Another provider in MD's practice referred Patient for repair and revision, which took place approximately 30 days after the initial hip replacement performed by MD. The Board's reviewing expert felt that MD should have revised the misposition and repaired the fracture.	Public Letter of Concern; MD shall complete CME on management of intraoperative orthopedic complications
SANGHI, Amit Kumar, DO (202302070) Raleigh, NC	11/18/2025	The Board is concerned about DO's care of a Patient who presented to the ED with a complaint of left upper quadrant abdominal pain, a burning sensation, and nausea without vomiting. DO's report concluded there were no acute findings on Patient's contrast abdomen/pelvis CT scan. Patient returned to the ED more than five months later with severe symptoms. Another abdomen/pelvis CT scan with contrast showed a	Public Letter of Concern: DO shall complete CME on the subject of abdomen and pelvis CT scans

		five-centimeter left upper quadrant mass suspected to be a cancerous lesion. The Board's reviewing expert immediately identified the mass upon review of the Patient's first CT images. In DO's response to the Board, he stated he measured the mass but failed to report it in his final dictation.	
MISCELLANEOUS ACTIONS			
SMITH, Brice Thomas, MD (200001536) Durham, NC	11/3/2025	MD reported that his privileges had been suspended by the Veterans Administration Palo Alto Health Care System in 2020. Board staff requested and submitted five of MD's patient records to the Board's reviewing expert who opined that MD's care for four of the five patients failed to conform to the standard of care. Specifically, in three cases an expanded differential, review of prior studies, and/or follow up imaging would be advised in managing an ambiguous finding. In the fourth case, the reviewing expert criticized MD's failure to review all images.	MD agrees to complete a general radiology remediation course
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			