Public

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 14, 2011

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Carlos F. Delos-Reyes, M.D.
REDACTED

Re: License No. 169564

Dear Dr. Delos-Reyes:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 11-149. This order and any penalty provided therein goes into effect June 21, 2011.

Please direct any questions to: Board for Professional Medical Conduct, 433 River Street, Suite 303, Troy, NY 12180, telephone # (518)402-0863.

Sincerely,

REDACTED
Katherine A. Hawkins, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Glenn Pezzulo, Esq.
Culley, Marks, Tanenbaum & Pezzulo, LLP
36 Main Street, Suite 500
Rochester, NY 14614-1790

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

CARLOS DELOS-REYES, M.D.

CONSENT

ORDER

BPMC No. 11-149

Upon the application of CARLOS DELOS-REYES, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 6/10/11

REDACTED

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

CARLOS DELOS-REYES, M.D.

CONSENT AGREEMENT AND ORDER

CARLOS DELOS-REYES, M.D., represents that all of the following statements are true:

That on or about March 18, 1987, I was licensed to practice as a physician in the State of New York, and issued License No. 169564 by the New York State Education Department.

My current address is REDACTED and I will advise the Director of the Office of Professional Medical Conduct ("OPMC") of any change of address.

I understand that the New York State Board for Professional Medical Conduct ("Board") has charged me with four specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and made part of this Consent Agreement.

I admit to Factual Allegations B and B.7, B and B.9 and B and B.10 in full satisfaction of the charges against me, and agree to the following penalty:

> Immediately upon issuance of the Consent Order for which I apply, my license to practice medicine shall be limited, pursuant to N.Y. Pub. Health Law § 230-a, to preclude patient contact and any practice of medicine, clinical or otherwise. I shall be precluded from

diagnosing, treating, operating, or prescribing for any human disease, pain, injury, deformity, or physical condition. I shall be precluded from further reliance upon my license to practice medicine to exempt me from the licensure, certification or other requirements set forth in statute or regulation for the practice of any other profession licensed, regulated or certified by the Board of Regents, Department of Education, Department of Health or the Department of State.

I further agree that the Consent Order for which I apply shall impose the following conditions:

- That Respondent shall, within 30 days of the issuance of the Consent Order, notify the New York State Education Department, Division of Professional Licensing Services, that Respondent's license status is "inactive," and shall provide proof of such notification to the Director of OPMC immediately upon having done so; and
- That Respondent shall return any and all official New York State prescriptions to the Bureau of Narcotic Enforcement, and shall surrender Respondent's Controlled Substance Registration Certificate to the United States Department of Justice, Drug Enforcement Administration, within 15 days of the Order's effective date. Further, within 30 days of returning these prescriptions and surrendering the registration, Respondent shall provide documentary proof of these transaction(s) to the Director of OPMC; and
- That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State; and

- That Respondent shall comply with all conditions set forth in attached Exhibit "B" ("Requirements for Closing a Medical Practice").

I stipulate that my failure to comply with any conditions of this Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in the future, this Consent Agreement, and Order, **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to N.Y. Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, or upon facsimile transmission to me or my attorney, whichever is first. The Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint.

In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I am aware and agree that, regardless of prior communication, the attorney for the Department, the Director of the Office of Professional Medical Conduct and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE: 23 MAY 11

REDACTED
CARLOS DELOS-REYES, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 5/24/11

REDACTED

GLENN PEZULLO, ESQ.
Attorney for Respondent

DATE: 5/27/11

REDACTED

JUDE B. MULVEY
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 6/10/11

REDACTED

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

CARLOS DELOS-REYES, M.D.

Amended
STATEMENT
OF
CHARGES

Carlos Delos-Reyes, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 18, 1987, by the issuance of license number 169564 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A at St. Joseph's Hospital and Family Services of Chemung County Mental Health Clinic ("FSCC") from on or about January 29, 2010 to on or about October 8, 2010. Respondent's care and treatment of Patient A deviated from acceptable standards of care in that:

1. Respondent failed to appropriately document Patient A's psychiatric history and/or history of drug and alcohol use at his psychiatric evaluation on January 29, 2010.
2. Respondent prescribed lithium carbonate to Patient A on April 9, 2010 without adequate medical indication and/or without performing an evaluation to determine Patient A's baseline kidney or thyroid function and/or without instructing Patient A to have a lithium level performed before his next session, or of the dangers of lithium toxicity, and/or failed to document such.
3. Respondent failed to timely order Depakote levels for Patient A and/or failed to document such.
4. Respondent failed to appreciate Patient A's symptomatology, including 30 pound weight loss, shaking hands and arms, nausea and twitching, and/or failed to document such.
5. Respondent failed to stop lithium treatment for Patient A after Patient A

failed to obtain lithium testing.

6. Respondent failed to follow up on the results of lithium testing for Patient A and/or failed to document such.
7. Respondent failed to timely diagnose Patient A's lithium toxicity and/or reduce or discontinue lithium carbonate when Patient A became toxic.
8. Respondent prescribed Xanax to Patient A on February 24, 2010 without adequate medical indication and/or failed to document such.
9. Respondent transcribed a prescription for Wellbutrin in Patient A's medical record but failed to actually prescribe the medication.

B. Respondent provided medical care to Patient B at Respondent's home at 268 Universal Avenue, Elmira, New York and/or at various locations in New York State from on or about November 28, 2005 to on or about April 22, 2009. Respondent's treatment of Patient B failed to meet acceptable standards of care in that:

1. Respondent, at various times between November 2005 and April 2009, violated appropriate therapeutic boundaries with Patient B in that:
   a. Respondent inappropriately accepted a kidney from Patient B while serving as his psychiatrist.
   b. Respondent failed to identify himself as the "friend" referenced in Patient B's medical record as justification for prescribing Provigil to Patient B in that "Patient wants to be more alert during the daytime so that he can continue to be the caretaker for his friend."
   c. Respondent directed Patient B to obtain a pharmacy list of Patient B's pharmacy records following a request by the Office of Professional Medical Conduct for a complete copy of Patient B's medical records.
2. Respondent diagnosed Patient B with hypersomnia without adequate medical justification, and/or failed to document such.
3. Respondent prescribed Provigil to Patient B without adequate medical justification, for Respondent's own benefit and/or without consulting Patient B's internist and/or primary physician.

4. Respondent prescribed ~~Levitra~~, ~~Lunesta~~, Mentax and/or Zyrtec for Patient B without adequate medical justification and/or failed to document such.
5. Respondent wrote prescriptions for medications for Patient B, including, but not limited to Alprazolam, Mentax, ~~Lunesta~~ and/or Zyrtec, without documenting those prescriptions in Patient B's medical record.
6. Respondent permitted and/or directed Patient B to complete diagnostic information and/or psychiatric intake on Patient B's November 28, 2005 Behavioral Intake Evaluation.
7. Respondent permitted and/or directed Patient B to write his own prescription for Percocet and/or Klonopin on May 7, 2009.
8. ~~Respondent failed to refer Patient B to a primary care physician before prescribing Levitra to Patient B.~~
9. Respondent's progress notes regarding Patient B's care were untimely, inaccurate and/or incomplete.
10. Respondent failed to maintain a medical record for Patient B in accordance with accepted medical standards and/or in a manner which accurately and/or adequately reflected his care of Patient B.
11. Respondent documented that he performed an evaluation of Patient B on November 28, 2005, when, in fact, any evaluation performed was not performed until sometime after May or June 2006.

C. Respondent provided medical care to Patient C at Respondent's home and/or at various locations in New York from on or about August 18, 2005 to on or about April 21, 2008.

1. Respondent failed to rule out sleep apnea before diagnosing Patient C with hypersomnia and/or failed to document such.
2. Respondent failed to consult with Patient C's primary physician before treating Patient C for hypersomnia and/or failed to document such.
3. Respondent failed to document any rationale for prescribing only seven tablets of Provigil at a time to Patient C.
4. Respondent failed to maintain an appropriate medication list for Patient C.
5. Respondent failed to keep and/or maintain appropriate medical records

for Patient C and/or inappropriately post-dated notes contained in that record.

6. Respondent permitted Patient C to complete physician sections of his Behavioral Health Intake Evaluation.
7. Respondent directed Patient C to obtain pharmacy printout of Patient C's pharmacy records following a request by the Office of Professional Medical Conduct for a copy of the complete medical record of Patient C.

D. Respondent provided medical care to Patient D at FSCC from on or about January 24, 2008 to on or about February 3, 2009. Respondent's care and treatment of Patient D deviated from acceptable standards of care in that:

1. Respondent failed to perform an adequate psychiatric evaluation and/or history of Patient D on January 24, 2008.
2. Respondent failed to refer Patient D for lab work to monitor his blood glucose and cholesterol/triglycerides and/or failed to document such.

E. Respondent provided medical care to Patient E at FSCC from on or about December 26, 2008 to on or about October 9, 2009. Respondent's care and treatment of Patient E deviated from acceptable standards of care in that:

1. Respondent failed to coordinate his treatment of Patient E with her therapist and/or to consider her therapist's progress notes and/or failed to document such.
2. Respondent failed to appropriately follow up on Patient E's Valproic acid levels and/or failed to document such.
3. Respondent failed to refer Patient E for metabolic lab studies and/or failed to document such.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence on a particular occasion in violation of New York State Education Law §6530(4) in that Petitioner charges:

1. The facts in Paragraphs A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A.6, and/or A and A.7.
2. The facts in Paragraphs B and B.1(a), B and B.7, and/or B and B.11; and/or
3. The facts in Paragraph C and C.5.

FOURTH THROUGH FIFTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with practicing the profession fraudulently or beyond its authorized scope in violation of New York Education Law §6530(1) in that Petitioner charges:

4. The facts in Paragraph B and B.11; and/or
5. The facts in Paragraph C and C.5.

SIXTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion in violation of New York Education Law §6530(3) in that Petitioner charges two or more of the following:

6. The facts in Paragraph A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8 and/or A and A.9, B and B.(1)(a), B and B.(1)(b), B and B.(1)(c), B and B.2, B and B.3, B and B.4, 5 and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and

B.10, and/or B and B.11, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6 and/or C and C.7, D and D.1, and/or D and D.2, E and E.1, E and E.2 and/or F and F.3.

SEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20) in that Petitioner charges:

7. The facts in Paragraphs B and B.10, B and B.11, C and C.5 and/or C and C.7.

EIGHTH SPECIFICATION

WILLFULLY MAKING A FALSE REPORT

Respondent is charged with willfully making or filing a false report in violation of Education Law §6530(21) in that Petitioner charges:

8. The facts in Paragraphs B and B.11 and/or C and C.5.

TENTH THROUGH FOURTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN AN ADEQUATE RECORD FOR EACH PATIENT

Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that Petitioner charges:

10. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.6, A and A.8 and/or A and A.9;
11. The facts in Paragraphs B and B.1(b), B and B.1(c), B and B.2, B and B.4, B and B.5, B and B.6, B and B.9, B and B.10, B and B.11 and/or B

and B.11;

12. The facts in Paragraph C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, and/or C and C.6;
13. The facts in Paragraph D and D.1 and/or D and D.2; and/or
14. The facts in Paragraph E and E.1, E and E.2 and/or E and E.3.

DATE: April 25, 2011
Albany, New York

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct