These charges are only allegations which may be contested by the licensee in an administrative hearing.

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

IN THE MATTER OF DENNY PACHECO, D.O.	NOTICE OF HEARING

TO: Denny Pacheco, D.O.
[redacted]

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on November 5, 2018, at 10:30 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, NY 10007-2919, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses

and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here [redacted]

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Riverview Center,150 Broadway - Suite 510, Albany, NY 12204-2719, ATTENTION: HON. JAMES HORAN, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the

Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATE September 13, 2018

[redacted]

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct

Albany,NY

Inquiries should be directed to:
Timothy J. Mahar, Associate Counsel
Bureau of Professional Medical Conduct
Rm 2512, Corning Tower
Empire State Plaza
Albany, New York 12237

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

IN THE MATTER OF DENNY PACHECO, D.O.	STATEMENT OF CHARGES

DENNY PACHECO, D.O., the Respondent, was authorized to practice medicine in New York State on or about September 9, 2010, by the issuance of license number 258600 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A, then a 7-month old female, (Patients are identified by name in Appendix A hereto) in the emergency department at Vassar Brothers Medical Center (VBMC) in Poughkeepsie, New York on March 17, 2013 for respiratory syncytial virus, and fever, among other conditions. Patient A returned to VBMC emergency department, approximately 6 hours following her discharge by Respondent from the emergency department with increased respiratory difficulty, fever, and retractions, among other conditions. Respondent's medical care of Patient A deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate Patient A's respiratory system on one or more occasions.
2. Respondent failed to adequately treat Patient A's fever.
3. Respondent failed to adequately evaluate Patient A prior to discharge.
4. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent provided medical care to Patient B, then a 25-year old male, in the emergency department of Arnot Ogden Medical Center in Elmira, New York on July 14, 2016, for a three-day history of nausea, vomiting, headache and lethargy, among other things. Patient B was discharged from the emergency department with a diagnosis of sinusitis and a prescription for Augmentin after having been treated in the emergency department with IV fluids, Zofran and Toradol, among other things. Patient B returned to the Arnot Ogden Medical Center emergency department approximately 17 hours following discharge with complaints of vomiting, lethargy and confusion, among other things. A lumbar puncture was performed and Patient B was admitted for presumptive meningitis. Patient B was transferred from Arnot Ogden Medical Center to Strong Memorial Hospital in Rochester, New York to continue treatment during the period from July 20, 2016 through September 8, 2016. Respondent's medical care of Patient B deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate Patient B during the July 14, 2016 emergency department visit for possible meningitis and/or encephalitis, including but not limited to, the failure to perform and/or order a lumbar puncture.
2. Respondent diagnosed Patient B with sinusitis, among other conditions, during the July 14, 2016 emergency department visit, without adequate medical indication.
3. Respondent failed to maintain an adequate medical record for Patient B.

C. Respondent provided medical care to Patient C, then a 61-year old female, in the emergency department of Arnot Ogden Medical Center on January 8, 2016 for injuries Patient C sustained in a motor vehicle accident approximately 35 minutes earlier, including four, consecutive, right-sided rib fractures, a fractured sternum, and a fractured patella. Patient C's medical history included, among other things, chronic obstructive pulmonary disease (COPD) and continued tobacco use. Following

evaluation and treatment, Respondent discharged Patient C with an incentive spirometer, among other things. Patient C returned to Arnot Ogden Medical Center on January 10, 2016 and was treated for hypoxia and confusion, among other things. Her medical history on January 10, 2016 included her non-compliance with the spirometer. Patient C was admitted to Arnot Ogden Medical Center for six days. Respondent's medical care of Patient C deviated from accepted standards of care as follows:

1. Respondent inappropriately discharged Patient C from the emergency department and/or failed to seek the admission of Patient C to the hospital on January 8, 2016.
2. Respondent failed to adequately and/or timely diagnose Patient C's patella fracture, and/or failed to adequately manage and/or treat the patella fracture.
3. Respondent discharged Patient C from the emergency department on January 8, 2016 without adequate pulmonary treatment and/or without adequate follow-up medical care of her pulmonary condition.
4. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent provided medical care to Patient D, then a 22-year old female, in the emergency department at VBMC on September 3, 2012 for right upper quadrant abdominal pain and vomiting, among other conditions. Respondent discharged Patient D with a diagnosis of upper right quadrant pain and with a referral to a surgeon. Patient D returned to the emergency department approximately 21 hours later at which time she was evaluated by Respondent for intense pain. A surgical consult was requested. Patient D was admitted and subsequently underwent a cholecystectomy. Respondent's medical care of Patient D deviated from accepted standards as follows:

1. Respondent failed to adequately evaluate Patient D's gallbladder on September 3, 2012.
2. Respondent failed to adequately re-evaluate Patient D prior to discharge from the emergency department on September 3, 2012.

3. Respondent, in discharging Patient D on September 3, 2012, failed to adequately manage her medical condition.
4. Respondent failed to document an adequate medical history and/or the performance of an adequate physical examination at the time of Patient D 's September 4, 2012 evaluation.
5. Respondent failed to maintain an adequate medical record for Patient D on September 3, 2012 and/or September 4, 2012.

E. Respondent provided medical care to Patient E, then a 50-year old male, with a history of COPD, diabetes, Body Mass Index of 29 kg/m2, and continued tobacco use among other conditions, in the emergency department at VBMC on June 2, 2014 for complaints of shortness of breath, and bilateral chest pain radiating to the left arm, among other conditions. An electrocardiogram performed in the emergency department showed, among other things, ST segment depressions. Approximately one hour after Respondent had entered a discharge diagnosis of COPD exacerbation with discharge instructions and outpatient prescriptions for COPD exacerbation in the patient's medical record, and then went off shift, Patient E suffered cardiac arrest in the emergency department and subsequently died. Respondent's medical care of Patient E deviated from accepted standards of care as follows:

1. Respondent failed to obtain an adequate cardiac history for Patient E.
2. Respondent failed to adequately interpret Patient E's EKG, and/or failed to adequately manage, evaluate and/or treat Patient E given the abnormal EKG findings.
3. Respondent failed to adequately monitor and/or evaluate Patient E's cardiac status, including, but not limited to, repeating cardiac enzyme and/or EKG testing.

4. Respondent failed to adequately diagnose and/or reassess Patient E prior to entering a discharge diagnosis, discharge instructions and outpatient treatment for COPD exacerbation in the medical record.
5. Respondent failed to adequately transfer the care of Patient E to the oncoming emergency room provider.
6. Respondent failed to maintain an adequate medical record for Patient E.

F. In an application for staff privileges which Respondent submitted to Arnot Ogden Hospital, Elmira, New York, on or about January 15, 2015 (Arnot Ogden Application), Respondent answered the following question "No":

> Has your employment, medical staff appointment, practice or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, discontinued, denied, relinquished, terminated, reduced, refused or limited in any hospital or health care facility or have proceedings toward any of those ends ever been instituted or recommended by an official, committee or governing body of any health care entity?

On or about January 15, 2015, Respondent signed the following attestation to the Arnot Ogden Hospital application:

> Denny J. Pacheco being duly sworn deposes and says that I, as the applicant, who makes the forgoing application, that I have read the foregoing application and know the contents thereof, and the same is true to the best of my knowledge and information.

Respondent's Arnot Ogden Application for staff privileges deviated from accepted standards of care as follows:

1. Respondent knew that his negative answer to the application question was false in that an official, committee or governing body of a hospital at which Respondent previously had hospital privileges had, on or about September 2, 2014 (and as accepted by that hospital's Board of Trustees on or about September 18, 2014), instituted or recommended proceedings to take one or more of the actions described in the Arnot Ogden Application question against Respondent's employment, medical staff appointment, practice or clinical privileges at that hospital. On or about October 23, 2014 Respondent requested a hearing pursuant to the provisions of the medical staff by laws to contest the actions which had been recommended against his employment, medical staff appointment or privileges. Respondent made the false answer on the application in an attempt to conceal from Arnot Ogden Hospital actions taken by another hospital against his practice at that hospital.

2. Respondent knew that his signed attestation of January 15, 2015 that "...I have read the foregoing application and know the contents thereof, and the same are true to the best of my knowledge and information." was false. Respondent made the false attestation on the application in an attempt to conceal from Arnot Ogden Hospital actions taken at another hospital against his practice at that hospitals.

G. In an application for temporary hospital privileges as a *locum tenens* which Respondent submitted to Ellis Medicine in Schenectady, New York, on or about December 1, 2016, and/or in a credentialing application for staff member privileges which Respondent submitted to Ellis Medicine (Ellis Hospital Application) on or about December 28, 2016 Respondent and/or Respondent's agent answered "No" to the following questions:

5. Have any disciplinary actions or investigations by any state licensing or disciplinary or regulatory board been initiated against you?

15. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare, Medicaid or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or sexual offense or sexual misconduct?

17. Have you ever received sanctions from or are currently the subject or [sic] investigation by any regulatory agencies (e.g., CLIA, OSHA, etc...)?

On or about December 1, 2016, Respondent signed the following attestation to the application for temporary privileges as a *locum tenens*, which provides in part:

> All information submitted by me in this application is true and complete to the best of my knowledge and belief. I fully understand that any relevant misstatement in or omission from this application may constitute cause or a denial of appointment to the Medical-Dental Staff of Ellis Medicine, or for the annulment or limitation of any appointment made upon the information contained in this application. Any misstatement or omission may also subject me to other disciplinary proceedings by the hospital.

On or about December 28, 2016, Respondent or his agent electronically signed the following attestation to the Ellis Medicine Application:

> I attest that all information in the Application is true and complete to the best of my knowledge and belief. I will notify the Organizations and/or their agents within 10 days of any material change to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of membership and/or privileges or affiliation by the Organizations, and must be submitted on-line or in writing, and must be dated and signed by me.

Respondent's application for temporary privileges as a *locum tenens* and/or the Ellis Medicine Application deviated from accepted standards of care as follows:

1. Respondent knew that the negative answer to question #5 above on the Ellis Hospital Application and/or his negative answer to question #5 above on the application for temporary privileges as a *locum tenens* were false in that an investigation of Respondent by a state disciplinary or regulatory board had been initiated prior to December 1, 2016. Respondent, or his agent, gave the false answer or answers described above to conceal from Ellis Medicine a state investigation of his medical practice.

2. Respondent knew that the negative answer to question #15 above on the Ellis Hospital Application and/or his negative answer to question #15 above in the application for temporary privileges as a *locum tenens* were false in that Respondent was currently the subject of an investigation by a state health program during the period including December 1, 2016 through December 28, 2016. Respondent, or his agent, gave the false answer or answers described above to conceal from Ellis Medicine a state investigation of his medical practice.

3. Respondent knew that the negative answer to question #17 above, on the Ellis Hospital Application and/or the negative answer to question #17 on the application for temporary privileges as a *locum tenens* were false in that Respondent was currently the subject of an investigation by a regulatory agency during the period including December 1, 2016 through December 28, 2016. Respondent, or his agents, gave the false answer or answers described above to conceal from Ellis Medicine a state investigation of his medical practice.

4. Respondent knew that his signed attestation of December 1, 2016 to the application for temporary privileges as a *locum tenens* that "All of the

information submitted by me in this application is true and complete to the best of my knowledge and belief," was false. Respondent, or his agent, made the false attestation to the supporting documents in an attempt to conceal from Ellis Medicine a state investigation of Respondent's medical practice.

5. Respondent knew that the signed attestation of December 28, 2016 to the Ellis Hospital Application that "I attest that all information provided in this Application is true and complete to the best of my knowledge and belief" was false. Respondent, or his agent, made the false attestation to the Ellis Hospital Application to conceal from Ellis Medicine a state investigation of Respondent's medical practice.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts as alleged in paragraphs A and A.1 and/or A and A.3.
2. The facts as alleged in paragraphs B and B.1.
3. The facts as alleged in paragraphs C and C.1.
4. The facts as alleged in paragraphs D and D.1.
5. The facts as alleged in paragraphs E and E.2 and/or E and E.3.

SIXTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

6. The facts as alleged in paragraphs A and A.1 and/or A and A.3.

7. The facts as alleged in paragraphs B and B.1.

8. The facts as alleged in paragraphs C and C.1.

9. The facts as alleged in paragraphs D and D.1.

10. The facts as alleged in paragraphs E and E.2 and/or E and E.3.

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in two or more of the following:

11. The facts as alleged in two or more of the following paragraphs: A and A.1, and/or A and A.2, and/or A and A.3, and/or A and A.4, and/or B and B.1, and/or B and B.2, and/or B and B.3, and/or C and C.1, and/or C and C.2, and/or C and C.3, and/or C and C.4, and/or D and D.1, and/or D and D.2, and/or D and D.3, and/or D and D.4, and/or D and D.5, and/or E and E.1, and/or E and E.2, and/or E and E.3, and/or E and F.4, and/or E and E.5, and/or E and E.6.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in two or more of the following:

12. The facts as alleged in two or more of the following paragraphs: A and A.1, and/or A and A.2, and/or A and A.3, and/or A and A.4, and/or B and B.1, and/or B and B.2, and/or B and B.3, and/or C and C.1, and/or C and C.2, and/or C and C.3, and/or C and C.4, and/or D and D.1, and/or D and D.2, and/or D and D.3, and/or D and D.4, and/or D and D.5, and/or E and E.1, and/or E and E.2, and/or E and E.3, and/or E and E.4, and/or E and E.5, and/or E and E.6.

THIRTEENTH THROUGH SEVENTEENTH SPECIFICATIONS

RECORD KEEPING

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) in that Respondent failed to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient as alleged in the following:

13. The facts as alleged in paragraphs A and A.4.

14. The facts as alleged in paragraphs B and B.3.

15. The facts as alleged in paragraphs C and C.4.

16. The facts as alleged in paragraphs D and D.4 and/or D and D.5.

17. The facts as alleged in paragraphs E and E.6.

EIGHTEENTH THROUGH NINETEENTH SPECIFICATIONS

FRAUD IN THE PRACTICE OF MEDICINE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession fraudulently as alleged in the following:

18. The facts as alleged in paragraphs F and F.1, and/or F and F.2.

19. The facts as alleged in paragraphs G and G.1, and/or G and G.2, and/or G and G.3, and/or G and G.4, and/or G and G.5.

TWENTIETH THROUGH TWENTY-FIRST SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report as alleged in the following:

20. The facts as alleged in paragraphs F and F.1, and/or F and F.2, and/or F and F.3.

21. The facts as alleged in paragraphs G and G.1, and/or G and G.2, and/or G and G.3, and/or G and G.4, and/or G and G.5.

DATE: September 13, 2018
Albany, New York

[redacted]

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct