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OSTEOPATHIC MEDICAL BOARD
OF CALIFORNIA

BEFORE THE
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **JEFFREY VON HILL, D.O.** **1050 Iron Point Rd.** **Folsom, CA 95630** **Osteopathic Physician's and Surgeon's Certificate No. 12845** Respondent.	Case No. 900-2018-000067 **FIRST AMENDED ACCUSATION**

PARTIES

1. Mark M. Ito (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Osteopathic Medical Board of California, Department of Consumer Affairs.

2. On or about June 28, 2013, the Osteopathic Medical Board of California issued Osteopathic Physician's and Surgeon's Certificate Number 12845 to Jeffrey Von Hill, D.O. (Respondent). The Osteopathic Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2023, unless

renewed. On or about March 3, 2021, the license was suspended pursuant to an Ex Parte Interim Suspension Order. On or about May 4, 2021, an Interim Order of Suspension was issued, suspending Respondent's license until a final resolution is reached in this administrative matter.

JURISDICTION

3. This First Amended Accusation is brought before the Osteopathic Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3600 of the Code states that the law governing licentiates of the Osteopathic Medical Board of California is found in the Osteopathic Act and in Chapter 5 of Division 2, relating to medicine, known as the Medical Practice Act.

5. Section 3600-2 of the Code states:

"'"The Osteopathic Medical Board of California shall enforce those portions of the Medical Practice Act identified as Article 12 (commencing with Section 2220), of Chapter 5 of Division 2 of the Business and Professions Code, as now existing or hereafter amended, as to persons who hold certificates subject to the jurisdiction of the Osteopathic Medical Board of California. . .'"

6. Section 2227(a) of the Code provides in pertinent part that a licensee whose matter has been heard by an administrative law judge. . .who is found guilty. . .may, in accordance with the provisions of this chapter: have his license revoked; have his right to practice medicine suspended for a period not to exceed one year upon order of the board; be placed on probation and be required to pay the costs of probation monitoring upon order of the board; be publicly reprimanded which may include relevant educational courses; or have any other action taken in relation to discipline as part of an order of probation.

7. Section 2452 of the Code provides that the Medical Practice Act applies to the Osteopathic Medical Board of California so far as it is consistent with the Osteopathic Act.

8. Section 2450.1 of the Code states:

> Protection of the public shall be the highest priority for the Osteopathic Medical Board of California in exercising its licensing, regulatory, and disciplinary functions.

Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

STATUTORY PROVISIONS

9. Section 822 of the Code states:

If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing section shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

10. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

11. Section 2234 of the Code states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

...

(e) The commission of any act involving dishonesty or corruption that is

substantially related to the qualifications, functions, or duties of a physician and surgeon.

...

12. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

13. Section 2239 of the Code states:

(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The Medical Board may order discipline of the licensee in accordance with Section 2227 or the Medical Board may order the denial of the license when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

14. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

15. Section 2280 of the Code states:

No licensee shall practice medicine while under the influence of any narcotic drug or alcohol to such extent as to impair his or her ability to conduct the practice of medicine with safety to the public and his or her patients. Violation of this section constitutes unprofessional conduct and is a misdemeanor.

4. Section 11153 of the Health & Safety Code states:

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

(b) Any person who knowingly violates this section shall be punished by imprisonment in the state prison or in the county jail not exceeding one year, or by a fine not exceeding twenty thousand dollars ($ 20,000), or by both a fine and imprisonment.

(c) No provision of the amendments to this section enacted during the second year of the 1981 82 Regular Session shall be construed as expanding the scope of practice of a pharmacist.

5. Section 11154 of the Health & Safety Code states:

(a) Except in the regular practice of his or her profession, no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person or animal which is not under his or her treatment for a pathology or condition other than addiction to a controlled substance, except as provided in this division.

(b) No person shall knowingly solicit, direct, induce, aid, or encourage a

practitioner authorized to write a prescription to unlawfully prescribe, administer, dispense, or furnish a controlled substance.

7. Section 11156 of the Health and Safety Code states:

(a) Except as provided in Section 2241 of the Business and Professions Code, no person shall prescribe for, or administer, or dispense a controlled substance to, an addict, or to any person representing himself or herself as such, except as permitted by this division.

(b)(1) For purposes of this section, addict means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section.

8. Section 11157 of the Health & Safety Code states that no person shall issue a prescription that is false or fictitious in any respect.

9. Section 11170 of the Health & Safety Code states that no person shall prescribe, administer, or furnish a controlled substance for himself.

10. Section 11171 of the Health & Safety Code provides that no person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

11. Section 11173 of the Health & Safety Code states:

(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

(b) No person shall make a false statement in any prescription, order, report, or record, required by this division.

(c) No person shall, for the purpose of obtaining controlled substances, falsely assume the title of, or represent himself to be, a manufacturer, wholesaler, pharmacist, physician, dentist, veterinarian, registered nurse, physician's assistant, or other authorized person.

(d) No person shall affix any false or forged label to a package or receptacle containing controlled substances.

13. Section 11175 of the Health & Safety Code states that no person shall obtain or possess a prescription that does not comply with this division, nor shall any person obtain a controlled substance by means of a prescription which does not comply with this division or possess a controlled substance obtained by such a prescription.

COST RECOVERY

16. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

17. Respondent owns and operates a Family Practice in Folsom, California, called Elevation Physicians.

18. During 2016, 2017, and 2018, Respondent regularly ordered injectable testosterone from drug manufacturer Henry Schein, at the rate of roughly one vial per month. On three occasions during these years, he also received deliveries of controlled medications other than testosterone from Henry Schein. Specifically, on or about August 31 2016, he received a delivery of clonazepam, diazepam, chloradiazepoxide and phentermine. On or about September 6, 2016, he received a delivery of hydrocodone, oxycodone, and Adderall. On or about December 25, 2017, he received a delivery of diazepam, lorazepam, clonazepam, injectable midazolam, zolpidem tartrate, and chloradiazepoxide.

19. Respondent told staff and the Henry Schein compliance officer that he needed these sedatives and opioids because he planned to provide urgent or emergency services at his facility and would need to be able to dispense medications to patients from his facility. However, the practice did not develop into an emergency or urgent care facility, and did not routinely dispense opioid and sedating medications to patients.

20. On or about December 2, 2016, Respondent filed a police report indicating that multiple controlled medications had been stolen from his vehicle as it was parked outside his office. He told police that he had been transporting controlled substances in his vehicle from one office to another, and that he had left the medications in his vehicle in a black duffel bag. He stated that he may have left a prescription pad in the bag, but could not recall. He said that only some of the medications in the bag had been taken. He stated that he was unsure exactly which medications had been taken.

21. Between approximately June of 2017 and January of 2018, Ms. A.S. worked for Respondent both in his medical practice and in his home as a nanny to his children. Ms. A.S. lived with Respondent's family between July and December of 2017. Shortly after Ms. A.S. began working for Respondent and living in his family home, he asked her if he could issue her a prescription for Klonopin, in her own name, that she would fill and return to him to administer to his child. He told her that his child has a medical condition requiring him to take six pills of Klonopin per day. Ms. A.S. agreed to this. Respondent then asked her if he could issue her a prescription for Adderall, again to be prescribed in her name, for her to fill and return to him to administer to himself. Ms. A.S. agreed to do it.

22. On or about July 30, 2017, Respondent provided Ms. A.S. with prescriptions for 60 tablets of 20 mg Adderall (amphetamine salt combo), and 60 1 mg tablets of Klonopin (Clonazepam). Ms. A.S. took the prescriptions to Walgreens and had them filled, and returned all of the pills for both prescriptions to Respondent.

23. Ms. A.S. continued to fill prescriptions for Adderall and Klonopin, from Respondent, in her name, and to return the pills to him during the months she worked for him and lived with him and his family. On or about October 19, 2017, Respondent was scheduled to meet with a patient to address her recent cancer diagnosis. Instead, Respondent left the office before meeting with the patient. Ms. A.S. was still at the office working, when Respondent texted her from his home, to inquire as to the status of the prescriptions she was to obtain for him. Ms. A.S. told Respondent that she had some more work to do, but would be able to fill the prescription for him that evening. She also advised Respondent via text that the cancer patient had been at the

office to see him and was upset that he was not there. He responded to Ms. A.S., via text, telling her to bring him his "happy sauce," and that he would take care of everything else.

24. During the months that Respondent was having Ms. A.S. fill and return to him the Adderall prescriptions, he was also receiving approximately 150 tablets, per month, of 10 mg Dexadrine (dextroamphetamine sulfate), from a physician, Dr. G.M. This physician worked at Elevation Physicians until approximately mid-2017. During the spring of 2017, Respondent requested early refills of medications from Dr. G.M., after reporting that his medication had been stolen, or that he had thrown it away. Eventually Dr. G.M. stopped prescribing to Respondent, and moved from Elevation Physicians to a practice in Auburn, California. Dr. G.M. reported that he had stopped providing care or prescriptions to Respondent in August of 2017, following multiple incidents when Respondent asked for early refills or had stated his medication was lost or destroyed. Dr. G.M. was concerned to see that Respondent had filled prescriptions from him in October and November of 2017.

25. Towards the end of 2017, a friend of Respondent, Dr. M.S., began working at Elevation Physicians and investing in the practice. In approximately December of 2017, Respondent asked Dr. M.S. to prescribe a stimulant to him, stating that he had suffered a brain injury in college, while playing recreational sports, and that he has taken the medication ever since. Dr. M.S verified this sports injury history with Respondent's wife, and began prescribing a stimulant to Respondent. In December of 2017, he prescribed 120 tablets of 10 mg Dexadrine, and another 90 tablets in January of 2018, as well as a benzodiazepine. On February 12, 2018, Dr. M.S prescribed 60 tablets of 30 mg Adderall. Beginning in January of 2018, Respondent also began seeing a physician in Wyoming, and obtaining prescriptions for stimulants and benzodiazepines. Respondent filled prescriptions from the physician in Wyoming, for Dexadrine, and Valium (diazepam), even though he was receiving prescriptions from Dr. M.S. Dr. M.S continued to prescribe benzodiazepines and stimulants to Respondent through March of 2018. The combined prescriptions for stimulants that Respondent filled in February and March of 2018, from Dr. G.M., the Wyoming physician and Dr. M.S, were well in excess of the maximum recommended doses of stimulant medications.

26. On or about February 21, 2018, the Board received a complaint that Respondent was providing poor patient care and abusing prescription medications. On or about April 4, 2018, Board investigators paid an unannounced visit to Respondent's office to interview him and obtain a biological fluid sample to test for drug use. During the visit, investigators asked Respondent what prescriptions he was taking. Respondent stated that he takes a Dexadrine for an old brain injury, and Valium, as well as occasional Norco (hydrocodone/acetominophen) which he stated he takes for nausea.[1] The results of the toxicology analysis showed that Respondent was positive for amphetamines, hydrocodone, and various metabolites of benzodiazepines consistent with his prescriptions. It was, however, also positive for metabolites of clonazepam and morphine, which is inconsistent with his prescribed medications.

27. Following the April 2018 visit from investigators, Dr. M.S stopped providing prescriptions for controlled medications to Respondent. Nonetheless, in September and November of 2018, Respondent approached Dr. M.S approximately three times, requesting that he prescribe stimulant medications. In September, Respondent told Dr. M.S., that his primary care physician was unavailable and asked Dr. M.S. to prescribe him a short course of stimulant medication to tide him over. Dr. M.S. prescribed a seven-day course of the stimulant to Respondent. When Respondent sought additional prescriptions, Dr. M.S reviewed Respondent's CURES history and was concerned to see the numbers and types of prescriptions filled from multiple pharmacies from multiple providers. Thereafter, Dr. M.S. refused to provide any further medication. Each time Respondent appeared surprised that Dr. M.S refused to prescribe the medications. Towards the end of 2018, Respondent established care with a primary care physician and a neurologist, who have been prescribing him stimulant medications through the present. The primary care physician is also a personal friend of Respondent and has invested financially in his practice.

28. During 2019, two additional mid-level providers began working at Elevation Physicians under Respondent's supervision. In April of 2019, a Nurse Practitioner (N.P.), Ms.

[1] Respondent's CURES report did not show that he had been prescribed hydrocodone in the previous two years. It did show a November 2017 prescription for 30 tablets of oxycodone.

A.H. began working at Elevation Physicians, and later in 2019, a Physician Assistant (P.A.), Ms. K.I., began working at Elevation Physicians. This was Ms. K.I.'s first job as a P.A., and Ms. A.H.'s first position providing primary care as an N.P. Initially, Ms. A.H. and Ms. K.I. noted that the practice seemed to suffer from a high rate of staff turnover, and found that there were frequently instances where their paychecks would bounce, or they would not be paid on time. However, as they continued working for Respondent, they began to grow concerned about the quality of care provided to patients. During the summer of 2020, they became increasingly concerned about Respondent's demeanor and behavior, and particularly his failure to show up for work, and erratic habits in abruptly canceling the rest of his patients for the day and leaving them to cover for him. It was around this time that one of Respondent's childhood friends, Patient 1, returned to California to work at Respondent's practice after many years away living in Florida.[2] In addition to being a friend, Respondent had been prescribing controlled medications to Patient 1 since at least May of 2018. Patient 1 had a history of drug and alcohol abuse. Respondent fired Patient 1 from his prior employment at his practice in approximately 2015 or 2016. During the Summer of 2020, Respondent rehired Patient 1 to work as the Office Manager at the practice.

28. In late summer or early fall of 2020, Both Ms. K.I. and Ms. A.H. reported that Respondent approached them separately, asking them to prescribe Adderall for his Respondent's father, who he said was visiting from Idaho and had forgotten to bring his medication with him. Ms. A.H. recalled that she was out of the office on vacation or leave, and that she received a text message from Respondent asking her to send a prescription to the pharmacy for Adderall for his father. Ms. A.H. delayed responding to the text, because she felt uncomfortable with the request. She ultimately told Respondent that she did not feel comfortable issuing the prescription. During the delay, Respondent had approached Ms. K.I. asking her to prescribe the Adderall for her father. Ms. K.I. reluctantly agreed to write the prescription, but she seemed to have accidentally sent it to the wrong pharmacy. When Ms. A.H. returned to the office the next day, Patient 1 approached her and told her that Respondent really needed her to prescribe the Adderall to his

[2] The patients referenced in this Accusation are referred to by numbers to protect their privacy. The full names and records of the patients will be provided to Respondent in discovery.

father because the prescription Ms. K.I. had issued went to the wrong pharmacy. Ms. A.H. reluctantly wrote the prescription and sent it to a pharmacy in California. Ms. A.H. and Ms. K.I. later learned that Respondent's father was not really visiting from Idaho, and was not even in California during this time.

29. Both Ms. K.I. and Ms. A.H. suspected that Respondent was abusing prescription medications and sharing medications with Patient 1. They both reported that Respondent and Patient 1 spent a lot of time together at the office, and that both appeared to have a similar look, of being red, sweaty, and jittery. One day at the Office, Respondent came to Ms. A.H. because he thought he might be having a heart attack. Ms. A.H. listened to his heart and found he was tachycardic. Ms. K.I. estimated that she observed Respondent present with what she interpreted to be drug-induced behavior approximately 20 times during the year she worked for him. On some of the occasions that she observed this behavior, Respondent was working and seeing patients.

30. On September 16, 2020, Respondent sent a text to Ms. K.I. asking her to prescribe Adderall to Patient 1. Ms. K.I. responded that she was busy with patients, and could not address the request immediately. Respondent continued to send her additional texts, while she was working and seeing patients. Patient 1 also approached her asking her if she had seen Respondent's text message. Eventually, Ms. K.I. reviewed Patient 1's CURES and saw that the prescription she was being asked to write would be an early refill of an increased dosage. She texted back to Respondent telling him that she was not willing to write the prescription.

31. Over the course of the texts Respondent continued to send Ms. K.I. from early afternoon through the evening, he became increasing incoherent to the point of being unintelligible. At one point during the day, Respondent sent the following text to Ms. K.I.:

> QHe has had an early
> Refill on meth beds. I would
> just show surgical
> Xaxamdkl
> Was
> Mecz
>
> If ks not

our friends
doc
Mothers thatat sock and do
know it. Happen that Gina mm
Question

32. Ms. A.H. reported that she had received similar nonsensical text messages from Respondent in the past, and both Ms. K.I. and Ms. A.H. reported that they had received telephone calls from Respondent, especially in the evenings, when he sounded slurred or incoherent. As a result of these concerns, Ms. K.I. and Ms. A.H. both left Respondent's practice at the end of September 2020. On Ms. K.I.'s last day working at the office, Respondent left early and she ended up having to see a patient who had been scheduled to see Respondent. He was a 90-year-old man, with a sore on his foot and multiple medical problems. Ms. K.I. was concerned that this last minute addition of a complicated patient to her workload left her with insufficient time to provide the level of care she felt was needed.

33. Prior to Ms. A.H.'s last day working at Elevation Physicians, a Confidential Patient (C.P.) presented to her for care. C.P. told Ms. A.H. that he used to see Respondent for care, but that he recently had an appointment with Respondent during which Respondent appeared to be intoxicated or under the influence of drugs or alcohol. Consequently, C.P. refused to see Respondent any longer.

34. CURES and pharmacy records show that in January of 2020, Respondent began increasing his prescribing of several controlled medications to his friend and Office Manager, Patient 1. Respondent prescribed both short and long acting opioids to him, as well as stimulants and benzodiazepines. Patient 1 frequently filled prescriptions for stimulants in high doses, multiple times per month from Respondent. In March of 2020, Pharmacist J.J. called Respondent to inquire about a stimulant prescription written by Respondent that Patient 1. was attempting to fill at the pharmacy. Pharmacist J.J. was unable to pull up Patient 1's CURES report, and so called Respondent to inquire about the prescription. Respondent explained that Patient 1 had just moved here from Florida and needed the medication as part of his continuing rehabilitation treatment. Pharmacist J.J. filled the prescription. Again in September 2020, Patient 1 sought to fill a prescription at the Pharmacy where Ms. J.J. works. Ms. J.J. called Respondent to inquire

why the patient required an increased amount of tablets. Respondent was not able to give a coherent answer, and Ms. J.J. declined to fill the prescription. Ms. J.J. was familiar with Respondent from years earlier, and found that his speech and manner during the two telephone calls in March and September 2020 were very different from years before. During the telephone calls Ms. J.J. noticed that Respondent's speech sounded slurred, and that he seemed to be having some mental confusion.

35. During the fall of 2020, staff at Complete Care Pharmacy also began to notice a change in Respondent's demeanor and behavior. Complete Care Pharmacy is a pharmacy that is physically connected to the building Respondent practices out of. Although Respondent does not have an ownership interest in the pharmacy, Complete Care Pharmacy occupies the same building adjacent to Respondent's practice location and many of Respondent's patients use that pharmacy due to its proximity. Pharmacist L.C. has worked at complete care since approximately the fall of 2020, and Pharmacist Technician B.P. has worked there for many years. Both observed that Respondent appeared altered and under the influence of some kind of substance since at least the fall of 2020. They noticed that his speech is tangential and slurred. The pharmacy received reports from several of Respondent's patients that he appeared scattered and unlike himself in the past few months. Complete Care Pharmacy declined to issue controlled medications to Respondent's family and employees due to concerns about potential abuse or misuse of medications. During the fall of 2020, Pharmacist L.C. declined to fill prescriptions for Patient 1 and his spouse due to these concerns.

36. During the months of August, September and October of 2020, Pharmacy staff received strange inquiries from Respondent about possible infection and contamination. Respondent told pharmacy staff that he believed there was black mold in the building that would require treatment with bleach and disinfectant. He reported to pharmacy staff that he believed he had a drug resistant bacterial infection and was taking samples of his body to test. He inquired of pharmacy staff what medication is recommended for treatment of parasitic worms. Respondent told his own staff and pharmacy staff that he believed he and Patient 1 were suffering from parasitic worms and required treatment.

37. On or about November 9, 2020, Board investigators made another unannounced visit to Respondent's practice. He provided a biological fluid sample. The sample tested positive for stimulants, and benzodiazepines, although Respondent's CURES patient activity report showed that he had not filled any prescribed benzodiazepines for over a year.

38. On or about November 16, 2020, Respondent was admitted to Sutter Roseville hospital with complaints of wounds to both his thighs, approximately 4 centimeters, that would not heal. Respondent was diagnosed with acute chronic abscesses to both thighs. Respondent reported to the hospital staff that he had been seeing a physician who had performed outpatient debridement over the past few months, and that the wounds had tested positive for MRSA. However, when Board investigators obtained the records of the physician Respondent stated had performed the debridement, there was no record of treatment until after his discharge in November 2016. Moreover, Sutter Roseville confirmed only mixed skin flora in the cultures taken from the wounds. Sutter staff also observed a smaller wound to Respondent's inner thigh, and swelling to his right forearm. Sutter physicians ordered an ultrasound of his right arm, and diagnosed him with a deep vein thrombosis of his right, radial vein. Sutter physicians further noted that the deltoid region of both Respondent's arms were red and hardened, with scaling from multiple puncture wounds.

39. Although the injuries to Respondent's arms and legs are consistent with intravenous and intramuscular injection of medications, Respondent gave inconsistent statements to Sutter staff on whether he was injecting medications. He denied intravenous drug use or use of any recreational drugs. Respondent indicated that he had received injectable medication for his brain injury at some point, but later denied injecting medications, and claimed he had only been injecting himself with vitamins. The hospitalist recommended Respondent consider alternate methods of administering vitamins to himself.

40. Respondent left Sutter Roseville on or about November 21, 2020, checking himself out against medical advice. The hospitalist noted that the "Patient exhibited strange behavior throughout hospitalization, was abusive to the nursing staff verbally, refused to give insurance information until the final day of hospitalization, was overall noncompliant with

recommendations." The discharge summary indicated that Respondent had been advised to remain in the hospital in order to have a wound vacuum placed, and to continue treatment for his deep vein thrombosis, but that he refused to stay. The hospitalist concluded that "the pattern of thrombosis, injections, and bizarre behavior during admission correspond to history of exogenous testosterone use, though this cannot be confirmed by history."

41. On or about December 9, 2020, Respondent participated in a voluntary examination by a Board-certified psychiatrist. The psychiatrist noted that Respondent presented well, and denied all abuse of prescription drugs. The psychiatrist concluded that if the allegations by his staff and coworkers were substantiated, that Respondent was using more prescription medication than indicated and that it was interfering with his work responsibilities, then it would support a diagnosis of substance abuse disorder. Shortly after the psychiatrist provided this finding, Board investigators provided her with additional, more recently obtained information. This additional information included the medical records from the November 2020 Sutter Roseville hospitalization, the statements of Ms. K.I. and Ms. A.H. concerning Respondent's unprofessional, drug seeking behavior with supporting text messages, medical records showing elevated liver enzymes, and tachycardia, and the testimony of a local pharmacist who reported that Respondent sounded impaired on the telephone in March and September. The psychiatrist further reviewed email messages and reports of telephone calls Respondent had exchanged with the Board investigator, in which he showed an altered communication styles and internal inconsistencies. With this updated information, the psychiatrist concluded that Respondent is suffering from a substance abuse disorder, moderate to severe, with likely abuse of stimulants and other controlled substances.

42. On or about December 18, 2020, Respondent called and spoke to a Board investigator. He told the investigator that he had to fire three of his staff members doing things that were "shady" in his office while he was in the hospital. Specifically, he told the investigator that one of his employees had claimed to have connections with drug cartels and threatened to kill him. He also reported that he had fired Patient 1 because he had relapsed on alcohol and had stolen his prescription pad. Pharmacy staff also relayed that Respondent had informed them that

Patient 1 had stolen his prescription pad. In approximately January of 2021, Pharmacy Technician B.P. had an encounter with Respondent that led him to believe Respondent was having hallucinations due to abusing drugs or medications. B.P. walked into Respondent's office and found Respondent sitting in a chair looking at his feet. When B.P. inquired if Respondent was okay, Respondent told B.P. that he thought rats or snakes were crawling on his feet. B.P. initially thought Respondent was joking, but when he appeared to be serious, B.P. put on the light from his phone and looked at Respondent's feet. B.P. observed electrical cords on the floor by Respondent's feet and told him that. Respondent appeared relieved and went on with his work.

43. On or about January of 2021, Ms. L.C. took her elderly mother to Respondent's practice for treatment. Ms. L.C. and her family had been patients of Respondent's practice for several years. She began seeing Respondent approximately 15 years ago, was pleased with his care, and found him to be very professional. More recently, Ms. L.C.'s elderly mother had fallen, broken her wrist, and required stitches. In approximately January of 2021, Ms. L.C. brought her mother to see Respondent to have stiches removed. Ms. L.C. and her mother waited for approximately an hour in the exam room before they were told that Respondent had an emergency and would not be able to see them for the appointment that day. The practice eventually arranged for other providers to cover for Respondent and remove the stitches, but it involved a delay and being moved to several different rooms.

44. In approximately the middle of February, 2021, Ms. L.C. returned to the practice with her adult daughter, Patient K.C., who was scheduled for an appointment with Respondent to evaluate a medical condition affecting her ears. Patient K.C. and her mother Ms. L.C. waited approximately 30 minutes for Respondent and the appointment lasted approximately 15 minutes. Patient K.C. and her mother both found Respondent's conduct at the appointment to be surprising and unprofessional. Respondent entered the treatment room for Patient K.C.'s appointment with his medical assistant. Respondent was wearing a track suit, and speaking on the telephone to his mother as he entered the room. He spoke on the phone for a few more seconds in the treatment room, saying goodbye to his mother in front of Ms. L.C., and Patient K.C. After he ended the call he made a remark to Ms. L.C. and Patient K.C. about how he sometimes has to lie to his mother.

Respondent asked Ms. L.C, and Patient K.C. if they would mind if he removed his covid mask as he finds masks to be uncomfortable. Both reluctantly agreed since they were each wearing masks themselves.

45. During the appointment both Ms. L.C. and Patient K.C. noted that Respondent appeared to be hyperactive. Patient K.C. has spent time around individuals who abuse prescription medication, including Adderall, and she formed the opinion that Respondent's behavior was consistent with a person abusing Adderall. After Respondent left the room, the first thing Patient K.C. said to her mother was that Respondent appeared to be "high as a kite." During the appointment both Ms. L.C. and Patient K.C. found Respondent to speak rapidly, to gesture quickly with his hands, to be excitable, and to make off-topic, random remarks. When Patient K.C. explained her ear symptoms, Respondent became very animated and apologized to her for the ear symptoms she was experiencing. Patient K.C. told Respondent that she had previously been diagnosed with an auditory processing disorder and he responded that was a "bullshit diagnosis." He made a telephone call to an otorhinolaryngologist seeking a referral for her and left a message in their presence. When he hung up the telephone, he told Patient K.C. and her mother that he believed she would need immediate surgery, probably that very week. This frightened both Patient K.C. and her mother. A few weeks later, Patient K.C. and her mother learned from a friend who is also a patient of Respondent's that his license had been suspended. In March of 2021, Ms. L.C. called the Board to report their experiences with Respondent.

Patient Prescribing Issues

Patient 1

46. Patient 1 was Respondent's long-time friend who had previously worked for Respondent and whom Respondent fired in approximately 2015-2016 for alcohol abuse and forging his prescriptions. Patient 1 resided primarily in Florida until during 2018 through mid-2020. Respondent began prescribing controlled medications to Patient 1 again in May of 2018, including multiple opioids and benzodiazepines. Respondent and his staff stated that Patient 1 would travel to California from Florida to see Respondent periodically for treatment during 2019. In summer of 2020, Respondent assisted Patient 1 to move to California and gave him a job as his

Office Manager at the practice. However, Patient 1 continued to fill prescriptions in both California and Florida throughout 2018, 2019, and 2020.

47. Although Respondent began prescribing controlled medications to Patient 1 in May of 2018, and prescribed both opioids and benzodiazepines to him every month, Respondent maintained no medical records for Patient 1 before 2019. Prior to 2020, the medical records consist exclusively of medication orders without any progress notes or examination or history. Respondent's medical records for Patient 1 contain only three documented patient encounters, dated April 27, 2020, May 19, 2020, and June 12, 2020. In these encounters, Respondent noted that Patient 1 was 70 days sober. The examination and past medical history is incomplete and the encounters note that the appointment is a remote appointment due to covid protocols. The treatment plans are inconsistent and contain no imagining reports or studies. Although the notes document that the "risks benefits and alternatives were discussed with patient," there is no insufficient detail provided to account for Patient 1's past addiction history, and the plan to protect his recovery or refer him to a pain management specialist or psychiatrist.

48. Narcan was prescribed only once and there was no consultation on its use. There are no urine drug screens documented. The records document patient self-escalation of doses. The morphine equivalent dose respondent prescribed exceeded the safe and standard dose at 240 MME/day. There was no documentation of the specific risks associated with this high dose or the concurrent use of benzodiazepines. There was no documentation of the multiple pharmacist concerns reported or the use of multiple pharmacies in multiple states.

49. After the encounter notes in spring of 2020, the rest of Respondent's medical records for Patient 1 are solely medication orders. Between September and November 2020 the medication orders contain notes to the pharmacy indicating that the patient lost several prescriptions in his car (September of 2020) or that his son flushed several medications down the toilet (October 2020). In November of 2020, Respondent placed a note on the prescription orders stating "He will no longer be a patient of mine. I do have med-legal responsibilities to refill he meds for the next 27 days." [sic]

Patient 2

50. Patient 2 was an employee of Respondent. She saw Respondent and other providers at the practice for treatment of musculoskeletal and menstrual pain. The treatment she received at the practice for these conditions, including a one-time, small dose of opioid medication for the menstrual pain was within the standard of care. Apart from this care, however, Respondent also prescribed the benzodiazepines clonazepam and alprazolam on a monthly basis to Patient 2 between July 2017 through December 2017. Respondent further prescribed several prescriptions of controlled medications to Patient 2 that he diverted for his personal use.

51. Despite the prescriptions for an anxiety condition, Respondent's medical records for Patient 2 fail to indicate any diagnosis, history or initial examination of anxiety in any way. There is no report of any anxiety complaints or symptoms, or whether any other alternate treatments had been tried for anxiety such as cognitive behavior therapy or non-controlled medications. There is no discussion of past treatment or prescribing for anxiety. Respondent failed to document any initial or periodic review of how the condition responded to the medications he prescribed. There was no documentation of a consultation or referral to psychiatry for anxiety. The records lack any notation of informed consent for treatment.

Patient 3

52. Patient 3 is a relative of Respondent. Patient 3 has been under the care of a specialist for a seizure disorder since at least 2016, and has received regular monthly prescriptions for benzodiazepines from this specialist since at least 2016. The specialist continued to provide medications for Patient 3 continuously from 2016 through December 20, 2020. Intermittently, the specialist was covered by another provider for an occasional month a few times per year, but it is clear from the prescription history that the specialist was Patient 3's main health care provider. The specialist at times alternated between clonazepam and lorazepam prescriptions for Patient 3 but never both at the same time.

53. Beginning in 2018, Respondent began concurrently prescribing benzodiazepines to Patient 3, in additional to his regular provider. Respondent's first prescription to Patient 3 was for lorazepam on March 10, 2018. On April 9, 2018, he prescribed 135 tablets of clonazepam.

Respondent escalated his prescribing to Patient 3 in the spring of 2020. From June 2020 forward, Respondent prescribed regular doses of lorazepam to Patient 3, in addition to his regular medication from the specialist. Respondent wrote prescriptions for 30 tablets of lorazepam to Patient 3, every month, with refills, from December 2019 through December 2020. Respondent falsely told Board investigators that he only ever wrote an occasional, short prescription for Patient 3 in an emergency, when the specialist was unavailable.

54. Respondent's medical records for Patient 3 lack any documentation of why he was concurrently prescribing benzodiazepines in addition to Patient 3's treatment with a specialist. Respondent's medical records for Patient 3 fail to contain a history and physical examination. There was no history or summary of other medications. The records contain no treatment plan or objectives, no informed consents, no reference to other diagnostic or treatment modalities, such as EEG, brain MRI, or developmental screeners. There were no monitoring labs drawn. In the medical records, there was not a mention of any consultations with other providers, in particular specialist Patient 3 was seeing as his primary provider for his seizure disorder. The records show that in addition to lorazepam, Respondent would also often prescribe Benadryl 50mg, intramuscularly for "sleep/seizure reduction." Respondent was, in fact, administering intramuscular Bendryl and benzodiazepines to himself during this period, and was diverting at least a portion of the medication he prescribed to Patient 3 for his own use.

Patient 4

55. Patient 4 is a relative of Respondent. From October 6, 2016 through January 7, 2021, Respondent prescribed controlled medications to Patient 4 for treatment of anxiety and insomnia. Respondent often prescribed 30 tablets of Ambien 10 mg to Patient 4 per month, in addition to a mixture of different benzodiazepines. He usually prescribed 30-60 tablets of 5 mg Ativan per month, as well as 30 tablets of 5 mg Valium. There were times during Patient 4's treatment course, when Respondent concurrently prescribed Ambien, Ativan and Valium all at once, as for example between April 2017 and June 2017. Patient 4 filled the prescriptions at multiple pharmacies.

56. Respondent's records for Patient 4 consist of 15 pages. In the review of the complete medical record, a history and physical was never taken. There was never a set of vitals, or a list of other conditions or medications that Patient 4 may be taking. No treatment plan or objectives were noted in the medical record. No informed consents were noted in the medical record. There was never mention in the record of other treatment modalities, such as counseling, SSRI medication, or sleep hygiene. Other than a CBC and RPR and Rapid Strep, there were no other lab orders to investigate underlying medical causes of anxiety and insomnia, such as hyperthyroidism. No consultation with Psychiatry or Behavior Health for counseling was ever noted in the medical record. Other than medication management with controlled substances, no other alternatives were offered.

FIRST CAUSE FOR ACTION

(Mental Illness and/or Physical Illness Affecting Competency)

57. Respondent is subject to action under section 822 in that he is not safe to practice medicine safely as he suffers from a mental illness that affects his competency to practice medicine.

58. Paragraphs 17 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Dangerous Use of Drugs or Alcohol)

59. Respondent is subject to disciplinary action under Code section 2239 in that he used controlled substances in a dangerous manner.

60. Paragraphs 17 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein.

61. Respondent's use of controlled medications as described in Paragraphs 18 through 41, to the extent and in such a manner as to be dangerous to himself or others, constitutes a violation of section 2239, thereby subjecting his license to discipline.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs Without Indication)

62. Respondent is subject to disciplinary action under Code section 2242 in that he prescribed, dispensed or furnished dangerous drugs without a prior examination or indication.

63. Paragraphs 17 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein.

64. Respondent's conduct of prescribed, dispensed or furnished dangerous drugs without a prior examination or indication constitutes a violation of section 2242, thereby subjecting his license to discipline.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Drug Statutes)

65. Respondent is subject to disciplinary action under Code section 2238, which establishes that it is unprofessional conduct for a physician to violate state law regulating dangerous drugs or controlled substances.

66. Paragraphs 17 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein.

67. Respondent's violation of the following provisions of the Health and Safety Code subject his license to discipline for unprofessional conduct under section 2238:

- Health and Safety Code section 11153 (Issuing a prescription for a controlled substance that is not for legitimate medical purposes in the usual course of his professional practice)
- Health and Safety Code section 11154 (Prescribing to a person not under his treatment/soliciting unlawful prescriptions)
- Health and Safety Code section 11156 (Prescribing to an addict)
- Health and Safety Code section 11157 (Issuing false/fictitious prescriptions)
- Health and Safety Code section 11170 (Prescribe/administer/furnish a controlled substance to oneself); and
- Health and Safety Code section 11173 (Obtaining a controlled substance by deceit).

FIFTH CAUSE FOR DISCIPLINE

(Practicing Medicine Under the Influence of Alcohol or Drugs)

68. Respondent is subject to disciplinary action under Code section 2280, in that he practiced medicine while under the influence of a narcotic drug or alcohol to the extent that it impaired his ability to practice safely.

69. Paragraphs 17 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

70. Respondent is subject to disciplinary action under Code section 2234, subdivisions (b) and/or (c), in that he was grossly negligent and/or repeatedly negligent in his care and treatment of Patients 1, 2, 3, and 4.

71. Paragraphs 17 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein.

72. Respondent was grossly and/or repeatedly negligent in his care and treatment of Patient 1, 2, 3, and 4 for his acts and omissions, including, but not limited to, the following:

a. Prescribing controlled medications to Patients 1, 2, 3, and 4 who were friends, relatives and coworkers, in contravention of ethical guidelines to ensure objectivity in the patient-physician relationship;

b. Prescribing controlled medications to Patients 2 and 3 that he diverted to his own use;

c. Failing to document, identify and respond to warning signs that Patient 1 was abusing prescription medications;

d. Prescribing an unsafe amount and combination of opioids and benzodiazepines to Patient 1; and

e. Failing to perform and document an adequate history and physical, treatment plan and objectives, informed consent, and consultation for prescribing controlled medications to Patients 1, 2, 3, and 4.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

73. Respondent is subject to disciplinary action under Code section under section 2234 in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as alleged in paragraphs 17 through 56, above, which are incorporated by reference and realleged as if fully set forth here.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Osteopathic Medical Board of California issue a decision:

1. Revoking or suspending Osteopathic Physician's and Surgeon's Certificate Number 12845, issued to Jeffrey Von Hill, D.O.;

2. Ordering Jeffrey Von Hill, D.O. to notify his patients, should he be placed on probation for sexual misconduct, of his probationary status pursuant to Business and Professions Code section 2459.4(a);

3 Ordering Jeffrey Von Hill, D.O. to pay the Osteopathic Medical Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: July 9, 2021

Mark M. Ito

MARK M. ITO
Executive Director
Osteopathic Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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DECLARATION OF SERVICE BY CERTIFIED MAIL AND FIRST CLASS MAIL
(Separate Mailings)

In the Matter of the First Amended Accusation Against:
Jeffrey Von Hill, D.O.
Case No: 900-2018-000067

I, the undersigned, declare that I am over 18 years of age and not a party to the within cause; my business address is 1300 National Drive, Suite 150, Sacramento, CA 95834.

On **July 9, 2021,** I served the attached **First Amended Accusation, Statement to Respondent, Request for Discovery, and Government Code Sections 11507.5, 11507.6 and 11507.7,** by placing a true copy thereof enclosed in a sealed envelope as certified mail with postage thereon fully prepaid and return receipt requested, and another true copy of the **First Amended Accusation, Statement to Respondent, Request for Discovery, and Government Code Sections 11507.5, 11507.6 and 11507.7** as enclosed in a second sealed envelope as first class mail with postage thereon fully prepaid, in the internal mail collection system at the Office of the Osteopathic Medical Board of California addressed as follows:

NAME AND ADDRESS	(certified and regular mail)
Jeffrey Von Hill, D.O. 105 Iron Point Rd. Folsom, CA 95630	Certified Mail No 9489 0090 0027 6244 3723 43
Jeffrey Von Hill, D.O. 2283 Keystone Dr. El Dorado Hills, CA 95762-9542	9489 0090 0027 6244 3723 50

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on July 9, 2021, at Sacramento, California.

James C. Sparks
Declarant

Signature

cc: Megan R. O'Carroll, Deputy Attorney General
Elizabeth M. Brady, Esq