STATE OF INDIANA)
)
COUNTY OF HENDRICKS)

IN THE HENDRICKS SUPERIOR COURT 4

STATE OF INDIANA

vs.

MELISSA R. SMITH

AFFIDAVIT FOR PROBABLE CAUSE

I, Cecelia Goddard, Drug Diversion Investigator for the Office of the Indiana Attorney General, Medicaid Fraud Control Unit, have probable cause to believe that Melissa R. Smith, in the County of Hendricks, State of Indiana, did commit the following crimes:

I.C. 35-48-4-14 (c) Obtaining a Controlled Substance by Fraud/Deceit: a Level 6 Felony

I.C. 35-48-4-14 (a)(3) Offenses Relating to Registration/Failure to Make a Record: a Level 6 Felony

1) I participated in the investigation of the criminal offenses described in this affidavit. The statements contained in this affidavit are founded, in part, on information provided to me through conversations or written statements and information from employees of Avon Health and Rehabilitation Center (also known as "The Village of Avon") and records related to this investigation. I believe these witnesses to be truthful and credible.
2) Because this affidavit is being submitted for the purposes of filing criminal charges I have not included all facts that have been revealed during the course of this investigation. I have set forth only the facts that are believed to be necessary to establish the required foundation for probable cause.
3) The Village of Avon is located at 4171 Forest Pointe Circle, Avon, in Hendricks County, Indiana 46123. The facility provides a continuum of care, including Independent Living, Assisted Living, Skilled Nursing Care, Memory Care and Rehabilitation.
4) Melissa R. Smith, DOB 11-15-74, is a Qualified Medication Aide ("QMA"), License Number QMA9500132. She was employed by The Village of Avon from 7-19-10 until she was terminated on 10-23-18, following an investigation into discrepancies with the administration of narcotic medications.
5) Wellfount is the Pharmacy of record servicing the Village of Avon. Wellfount is located at 5751 West 73rd Street, Indianapolis, Indiana, and is registered with the Indiana State Board of Pharmacy to dispense controlled substances. Under both state (I.C. 35-48-3-3 (e)(1) and federal law (21 C.F.R. 1301.22), Melissa R. Smith is exempted from registering separately with the state or federal government to handle controlled substances, due to being an authorized employee or agent of a registered party, to wit: Wellfount; as long as she is acting in the usual course of her employment.
6) Wellfount, along with The Village of Avon and its employees or agents, acting in the usual course of their employment, are required to maintain complete and accurate records under both Indiana and Federal laws pertaining to the dispensation of all controlled substances. Specifically, I.C. 35-48-3-7 mandates that records be kept in conformance with the record-keeping requirements of federal law and regulation and with any additional rules the Indiana

State Board of Pharmacy issues.

Title 21 Code of Federal Regulations (C.F.R.) 1304.22 (21 C.F.R. 1304.22) require a complete and accurate record be maintained for the dispensing or administration of a controlled substance to a patient, including:

a. Number of units or volume of drug dispensed
b. Name and address of the person to whom it was dispensed
c. Date of dispensing
d. Number of units or volume dispensed
e. Written or typewritten name or initials of the individual who dispensed or administered the substance.

In addition, Federal Regulations mandate any controlled substance that is removed for dispensing, but not actually given to the patient must be destroyed in accordance with 21 C.F.R. 1317.05 and 1317.05 and 1317.95(d), which requires that the destruction be witnessed by another employee/agent of the registrant. To maintain a proper inventory, a drug destruction record must be made.

7) The Village of Avon and Wellfount utilize an Automatic Dispensing Unit ("ADU") for storing and dispensing medications. The ADU is housed in a locked medication room. Medications are removed from the ADU by authorized staff members who must enter a unique access code.
8) Drugs are taken from the ADU and placed in one of 6 locked medication carts – one per unit—for purposes of administration to the facility residents. There are two keys for each locked medication cart: one remains locked in the office of the Director of Nursing, and the other is kept by a nurse or QMA on duty for the shift. Each cart has unique keys. The narcotics on each cart are counted at the start and at the end of every shift by both the off-going nurse or QMA and the in-coming nurse or QMA assigned to the medication cart that day. The keys to that cart are exchanged at the narcotics count.
9) Assigned staff members who are permitted to remove and dispense medications from the ADU or the medication cart, must complete an entry in the Medication Administration Record ("MAR") when a medication is administered to a resident. A MAR is the report that serves as a legal record of the drugs that have been administered to a patient by a health care professional, and is a part of the patient's permanent medical record. Any controlled substance that is removed from the ADU or medication cart that is not actually given to a resident and that cannot be returned (for example, if it was removed from a package or dropped on the floor) must be witnessed by another staff member and must be destroyed. The staff member and witness must then sign a corresponding Drug Disposition Log.
10) On 10-16-2018 there was a regularly scheduled staff meeting at The Village of Avon. On this day, Ashley Brummett, the Director of Nursing, was on vacation and the Assistant Director of Nursing, Cindy Allen ("ADON Allen") was filling in for her. Staff Nurse Kristen Welker ("Welker") was also attending the meeting. During the meeting Welker began looking over the routine Pharmacy Pull Reports. Welker reports that she didn't initially notice any particular trends right away, but after further review she noticed that three residents seemed to be receiving several more PRN (or "as needed") medications in comparison to all other residents. Welker jotted down the names of those three residents with the intent of looking at their MARs after the meeting.

11) Following the staff meeting, Welker went to a computer and began to examine the MARs for the three facility residents (CP, ME and LR) who appeared to be receiving frequent PRN medications that were administered by QMA Melissa Smith. Welker reports that she began finding documentation discrepancies, so she immediately notified ADON Allen and the facility Administrator David Ashbaugh ("HFA Ashbaugh") of her discovery.
12) Following notification of the problem, HFA Ashbaugh, ADON Allen and Welker began a complete audit of the MARs of the three residents in question, to ensure that they were not accidently overlooking documentation. During this audit they also examined the Progress notes for each of these residents. These notes are to be kept current for each resident to indicate pain level, location, treatment, response to medication and treatment etc. It was determined that multiple medication administrations had not been documented by QMA Melissa Smith in the residents' MARs as required. Further, there were no progress notes for any of the three residents whose medical records were reviewed.
13) The records show that during the two weeks that QMA Melissa Smith was off work on vacation, the same residents who were having high PRN medication administrations by QMA Melissa Smith did not request or require any PRN medications during her two week absence. Following this discovery, ADON Allen notified the pharmacy of the multiple discrepancies.
14) As the internal facility investigation continued, ADON Allen contacted Wellfount Pharmacy and requested "Pull Reports" specifically for QMA Melissa Smith for the months of July 2018 to October 31, 2018. Upon further examination, ADON Allen reports she found the following discrepancies (patient names redacted for privacy):

<u>JULY 2018</u>

a. Resident: C. P. 58 Norco 5-325mg removed for administration by Smith
No record of administration in the MAR

b. Resident: N. P. 10 Tramadol 50mg removed for administration by Smith
No record of administration in the MAR

c. Resident: L. R. 1 Norco 5-325mg removed for administration by Smith
No record of administration in the MAR

d. Resident: M. E. 29 Oxycodone 5-325mg removed for administration by Smith
No record of administration in the MAR

<u>AUGUST 2018</u>

e. Resident: C. P. 62 Norco 5-325mg removed for administration by Smith
No record of administration in the MAR

f. Resident: N. P. 5 Tramadol 50mg removed for administration by Smith
No record of administration in the MAR

g. Resident: L. R. 5 Norco 5-325mg removed for administration by Smith
No record of administration in the MAR

h. Resident: M. E. 6 Oxycodone 5-325mg removed for administration by Smith
No record of administration in the MAR

SEPTEMBER 2018

i. Resident: C. P. 38 Norco 5-325mg removed for administration by Smith
28 not documented as being administered in the MAR

j. Resident: L. R. 8 Norco 5-325mg removed for administration by Smith
No record of administration in the MAR

k. Resident: S. H. 1 Norco 5-325mg removed for administration by Smith
No record of administration in the MAR

OCTOBER 2018

l. Resident: C. P. 29 Norco 5-325mg removed for administration by Smith
20 not documented as being administered in the MAR

m. Resident: L. R. 10 Norco 5-325mg removed for administration by Smith
6 not documented as being administered in the MAR

n. Resident: S. H. 4 Norco 5-325mg removed for administration by Smith
3 not documented as being administered in the MAR

15) Following the discovery of QMA Melissa Smith's documentation discrepancies involving narcotic medications, HFA Ashbaugh and ADON Allen opted to speak with her, since she was working that day. QMA Melissa Smith was asked to report to the facility Administrator's office. During the investigative meeting, QMA Melissa Smith was asked about the multiple discrepancies and missing documentation in the MARs. QMA Melissa Smith responded that she "gets busy and forgets." The records indicate that QMA Melissa Smith had no discrepancies when it came to the administration of all other non-controlled medications—only those involving narcotic medications.
16) While conducting the Internal Investigation it was discovered that QMA Melissa Smith did not complete progress notes for any of the residents that she was caring for and treating. Facility protocol requires that Progress Notes should indicate the resident's pain level, location of pain, treatment rendered, response to the treatment, etc. when a medication is administered. QMA Melissa Smith was identified as the only staff member who was reporting that she administering pain medications to some residents who never complained of pain and never asked for the pain medication.
17) At the conclusion of the meeting with HFA Ashbaugh and ADON Allen, QMA Melissa Smith was asked to submit to a drug screen and she agreed to do so. She was also advised that her employment at The Village of Avon suspended pending further investigation. At the conclusion of this meeting HFA Ashbaugh contacted the Hendricks County Sheriff's Department to report the narcotic discrepancies.

18) On 10-16-2018 at approximately 02:00 P.M. Hendricks County Sheriff's Department Officers M. Smith #32823 and C. Smith #42061 were dispatched to The Village of Avon on report of a theft. Officers arrived on the scene and met with Nurse Welker and HFA Ashbaugh. The Officers were provided with the results of the facility's internal investigation. Officer M. Smith generated a report and he referred the case over to the Hendricks County Sheriff's Department Detective Sergeant D. Donaldson #D5996 for further investigation.
19) Detective Donaldson obtained the facility policies, procedures and protocols for the administration of medications at The Village of Avon and contacted Melissa Smith and scheduled an interview with her to discuss the facility's allegations.
20) On October 17, 2018 Melissa Smith arrived at the Hendricks County Sheriff's Department for the scheduled interview with Detective Donaldson. The interview was recorded on video and Detective Donaldson provided a copy to me as well. Detective Donaldson reports that during their conversation, Melissa Smith reported that she removed the controlled narcotic medications from the medication cart. Melissa Smith also stated to Detective Donaldson that she had forgotten to document the medication administrations in the resident's Medication Administration Records. Melissa Smith acknowledged that she had failed to follow the facility protocols. Melissa Smith told Detective Donaldson that her lack of documentation was due to being overloaded with patients and the large work load.
21) On 10-23-2018 Melissa Smith was officially terminated from The Village of Avon, for "Failure to follow medication administration rules, No documentation on 90 plus PRN medications".
22) This investigation reveals that Melissa Smith had approximately 90 transactions that resulted in 266 pills that are not documented in the patients' MARs and are unaccounted for between July 1st, 2018 and October 31, 2018.
23) While employed at The Village of Avon, Melissa Smith recklessly, knowingly or intentionally failed to make, keep or furnish a record, a notification, an order form, a statement, an invoice or information required under article and I.C. 35-48-4-14(a)(3).
24) This investigation reveals on at least 90 occasions between July 1st, 2018 and October 31, 2018, Melissa Smith knowingly or intentionally acquired possession of a controlled substance; to wit: Oxycodone, Norco (brand name for Hydrocodone/Acetaminophen), and Tramadol, by misrepresentation, fraud, forgery, deception, subterfuge or concealment of a material fact in violation of I.C. 35-48-4-14(c).

I swear, under the penalty for perjury as specified by I.C. 35-44.1-2-1 that the foregoing is true to the best of my information and belief.

/s/ *Cecelia Goddard*

Cecelia Goddard, Diversion Investigator
Indiana Medicaid Fraud Control Unit