STATE OF INDIANA) **IN THE LAGRANGE CIRCUIT/SUPERIOR COURT**
) SS:
COUNTY OF LAGRANGE) **CAUSE NUMBER. 44**

STATE OF INDIANA

VS

SHERI L. HAPNER

DOB: [redacted]

OLN: [redacted]

Count I:
INFORMATION FOR FAILURE TO MAKE, KEEP OR FURNISH RECORDS
A LEVEL 6 FELONY I.C. 35-48-4-14(a)(3)

Kathy Franko, Investigator with the Indiana Attorney General's Office, says that between November 3, 2024 and January 8, 2025, in LaGrange County, State of Indiana, Sheri L. Hapner did recklessly, knowingly or intentionally fail to make, keep or furnish a record or information as required by I.C. 35-48.

All of which is contrary to the statute, in such cases made and provided, and against the peace and dignity of the State of Indiana.

I hereby affirm under the penalties of perjury, as specified by I.C. 35-44.1-2-1, that the foregoing information is true and correct.

WITNESSES:
Joani N. Avila
Kathy Franko
Eric Hunter
Amanda LaCount
Sarah Marble
Nicholas J. Martin
Lori Miller
Brooke Richardson
Christopher J. Smith

Approved by: _/s/ Robin Gillman_____
Deputy Attorney General

STATE OF INDIANA) **IN THE LAGRANGE CIRCUIT/SUPERIOR COURT**
) SS:
COUNTY OF LAGRANGE) **CAUSE NUMBER. 44**

STATE OF INDIANA

VS

SHERI L. HAPNER

DOB: [redacted]

OLN: [redacted]

Count II:
INFORMATION FOR FURNISHING FALSE OR FRAUDULENT INFORMATION
A LEVEL 6 FELONY I.C. 35-48-4-14(b)(3)

Kathy Franko, Investigator with the Indiana Attorney General's Office, says that on or about January 6, 2025, in LaGrange County, State of Indiana, Sheri L. Hapner did knowingly or intentionally furnish false or fraudulent material information in a report or document, to-wit: medical record; required to be kept or filed by I.C. 35-48.

All of which is contrary to the statute, in such cases made and provided, and against the peace and dignity of the State of Indiana.

I hereby affirm under the penalties of perjury, as specified by I.C. 35-44.1-2-1, that the foregoing information is true and correct.

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STATE OF INDIANA) **IN THE LAGRANGE CIRCUIT/SUPERIOR COURT**
) SS:
COUNTY OF LAGRANGE) **CAUSE NUMBER. 44**

STATE OF INDIANA

VS

SHERI L. HAPNER

DOB: [redacted]

OLN: [redacted]

Count III:
INFORMATION FOR OBTAINING A CONTROLLED SUBSTANCE BY FRAUD OR DECEIT
A LEVEL 6 FELONY I.C. 35-48-4-14(c)

Kathy Franko, Investigator with the Indiana Attorney General's Office, says that between November 3, 2024 and January 8, 2025, in LaGrange County, State of Indiana, Sheri L. Hapner did knowingly or intentionally acquire possession of a controlled substance, to-wit: hydrocodone, a schedule II controlled substance; by misrepresentation, fraud, forgery, deception, or subterfuge.

All of which is contrary to the statute, in such cases made and provided, and against the peace and dignity of the State of Indiana.

I hereby affirm under the penalties of perjury, as specified by I.C. 35-44.1-2-1, that the foregoing information is true and correct.

WITNESSES:
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Approved by: /s/ Robin Gillman
Deputy Attorney General

STATE OF INDIANA) **IN THE LAGRANGE CIRCUIT/SUPERIOR COURT**
) SS:
COUNTY OF LAGRANGE) **CAUSE NUMBER. 44**

STATE OF INDIANA

VS

SHERI L. HAPNER

DOB: [redacted]

OLN: [redacted]

Count IV:
INFORMATION FOR OBTAINING A CONTROLLED SUBSTANCE BY FRAUD OR DECEIT
A LEVEL 6 FELONY I.C. 35-48-4-14(c)

Kathy Franko, Investigator with the Indiana Attorney General's Office, says that between November 3, 2024 and January 8, 2025, in LaGrange County, State of Indiana, Sheri L. Hapner did knowingly or intentionally acquire possession of a controlled substance, to-wit: hydrocodone, a schedule II controlled substance; by misrepresentation, fraud, forgery, deception, or subterfuge.

All of which is contrary to the statute, in such cases made and provided, and against the peace and dignity of the State of Indiana.

I hereby affirm under the penalties of perjury, as specified by I.C. 35-44.1-2-1, that the foregoing information is true and correct.

WITNESSES:
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Christopher J. Smith

Approved by: /s/ Robin Gillman
Deputy Attorney General

STATE OF INDIANA	)	**IN THE LAGRANGE COUNTY COURT**
	) **SS:**	
COUNTY OF LAGRANGE	)	**CAUSE NO.**

STATE OF INDIANA	)
	)
VS.	)
	)
SHERI LYNN HAPNER	)

AFFIDAVIT OF PROBABLE CAUSE

I, Kathy Franko, Diversion Investigator for the Indiana Attorney General Medicaid Fraud Control Unit, have good cause to believe that between November 3, 2024, and January 8, 2025, in the County of LaGrange, State of Indiana the above-named person committed the crimes of:

Failure to Make, Keep or Furnish Records - I.C. 35-48-4-14(a)(3), a Level 6 Felony
Furnishing False or Fraudulent Information - I.C. 35-48-4-14(b)(3), a Level 6 Felony
Obtaining a Controlled Substance by Fraud or Deceit – I.C. 35-48-4-14(c), a Level 6 Felony

I am a Diversion Investigator with the Indiana Office of the Attorney General Medicaid Fraud Control Unit (MFCU) and have been employed by the MFCU since June 2015. I am currently assigned to the Winamac, Indiana office. Prior to being hired by the MFCU, from November 1988 to June 2015, I was employed as a Trooper by the Indiana State Police (ISP). For approximately 22 of my 27 years with ISP, I was assigned as an Undercover Investigator in the Drug Enforcement Section (DES), and for approximately the last 10 years with ISP DES as a Diversion Investigator. As an Undercover/Diversion Investigator with ISP and with MFCU, I have been involved in numerous narcotics investigations involving diversion, theft of drugs from health care facilities, drug trafficking and health care providers prescribing controlled substances outside the scope of their practice or without medical necessity. I have received specialized training in the investigation of Medicaid Fraud, health care fraud, theft and related crimes, and the diversion of controlled substances by medical professionals.

1) I participated in the investigation of the offenses described within this affidavit. The statements contained in this affidavit are based in part on information provided by conversations with and written statements and information from residents and employees of Waters of LaGrange Rehabilitation and Skilled Nursing Center ("Waters of LaGrange"). I believe these witnesses to be truthful and credible.

2) Because this affidavit is being submitted for the purpose of securing an arrest warrant, I have

not included each and every fact that has been revealed through the course of this investigation. I have set forth only the facts that are believed to be necessary to establish the required foundation for issuance of the requested warrant.

3) Sheri Lynn Hapner ("Hapner") was born [redacted]. She is a Licensed Practical Nurse (LPN), licensed by the State of Indiana, on August 28, 2000, License Number 27048341A.

4) Hapner was employed by Waters of LaGrange from September 25, 2024, to January 19, 2025. Hapner's last shift was on Sunday, January 19, 2025. After her shift, Hapner resigned from Waters of LaGrange by leaving a resignation letter for Administrator Eric Hunter ("Hunter").

5) Waters of LaGrange is a Skilled Care/Nursing Home, located at 787 North Detroit Street, LaGrange, LaGrange County, Indiana 46761. Waters of LaGrange utilizes United Rx as their primary pharmacy. United Rx 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), Hapner is exempted from registering separately with the state or federal government to handle controlled substances due to being an authorized employee of a registered party, to wit: Waters of LaGrange, as long as she is acting in the usual course of her employment.

6) Waters of LaGrange 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, Indiana Code (I.C.) 35-48-3-7 mandates that records be kept in conformance with the record-keeping requirements of federal law and regulations and with any additional rules the Indiana State Board of Pharmacy issues including 856 IAC 1-28.1-12. Title 21 United States Code (U.S.C.) 827(a)(3) and Title 21 Code of Federal Regulations (C.F.R.) 1304.22 (21 C.F.R. §1304.22) requires that 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 Regulation 21 C.F.R. § 1317.95(d) mandates any controlled substance that is removed for dispensing, but not actually given to the patient must be witnessed by another staff member and may be destroyed. If destroyed, then a drug destruction record must be made.

7) Waters of LaGrange utilizes medication carts to store and dispense medications to patients within their facility. Narcotics are double locked within the medication carts and only one

nurse has a key to that cart during their shift. At shift change, both nurses count the cart together prior to turning over the keys and custody of the cart. Assigned nurses remove medications from the carts per a physician order. When drugs are delivered to the facility, there is an associated paper Narcotic Count Sheet (also called the Controlled Substance Record or "CSR") that keeps track of the doses of the medication. When drugs are removed from the medication cart, and dispensed to a patient, the nurse completes an Electronic Medication Administration Record (EMAR) and documents the date, time and quantity of the drug remaining in stock on the Controlled Substance Record/Report (CSR).

8) An EMAR is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The EMAR and the CSR are a part of patients' permanent record in their medical chart. The health care professional is required to document in the EMAR each time that medication is administered and the CSR each time the medication is dispensed.

9) This investigation started when Waters of LaGrange Director of Nursing, Sarah Marble ("Marble") noticed one of the Residents, [redacted] ("[redacted]") who usually doesn't have pain, seemed to only be in pain when Hapner worked. The last time his PRN (as needed) Oxycodone 5mg tablets had been administered by any other nurse was October 2024.

10) The physician order for [redacted] was that he was to be administered 2 tablets of 5mg Oxycodone (10mg total) by mouth every 4 hours, as needed (PRN) for pain. Oxycodone is an opioid and classified as a Schedule II Controlled Substance.
    a) November 3, 2024, Hapner signed out on 2 Oxycodone on the CSR at 1:45 p.m. Nothing was documented on the EMAR as administered.
    b) November 16, 2024, Hapner signed out 2 Oxycodone on the CSR at 2:30 p.m. Nothing was documented on the EMAR as administered.
    c) November 20, 2024, Hapner signed out 2 Oxycodone on the CSR at 1:00 p.m. Nothing was documented on the EMAR as administered.
    d) December 4, 2024, Hapner signed out 2 Oxycodone on the CSR at 2:30 p.m. Nothing was documented on the EMAR as administered.
    e) December 7, 2024, Hapner signed out 2 Oxycodone on the CSR at 5:30 p.m. Nothing was documented on the EMAR as administered.
    f) December 9, 2024, Hapner signed out 2 Oxycodone on the CSR at 3:30 p.m. Nothing was documented on the EMAR as administered.
    g) December 15, 2024, Hapner signed out 2 Oxycodone on the CSR at 10:30 a.m. Nothing was documented on the EMAR as administered.
    h) December 18, 2024, Hapner signed out 2 Oxycodone on the CSR at 4:30 p.m. Nothing was documented on the EMAR as administered.
    i) December 23, 2024, Hapner signed out 2 Oxycodone on the CSR at 4:00 p.m. Nothing was documented on the EMAR as administered.
    j) January 6, 2025, Hapner signed out 2 Oxycodone on the CSR at 10:00 a.m. Nothing was documented on the EMAR as administered.
    k) January 8, 2025, Hapner signed out 2 Oxycodone on the CSR at 7:45 a.m. Nothing was documented on the EMAR as administered.

11) On each of the above dates/times, Hapner signed out Oxycodone on the CSR, but didn't record she administered the Oxycodone to [redacted] in the Electronic Medication Administration Record (EMAR). Marble obtained permission from [redacted] family and a physician's order to perform a Urine Drug Screen (UDS) on [redacted].

12) On January 8, 2025, at approximately 8:00 p.m., QMA Amanda LaCount collected [redacted] urine specimen in an Integrated E-Z Split Key Drug Test Cup and locked it in Marble's office. At approximately 8:02 p.m. Marble collected the urine specimen from her office and advised the UDS result was negative for Opiates. United Rx told Marble that had the Oxycodone been administered to [redacted], it should have been in his system for four days.

13) Marble reviewed documentation and interviewed other residents when she found discrepancies in the documentation. Resident [redacted] ("[redacted]") advised he only requests pain medications in the middle of the night when his foot "goes bonkers". [redacted] Norco CSR showed removal times by Hapner that were uncharacteristic for [redacted]. When they interviewed [redacted], he said he hadn't gotten Norco at those times and hadn't gotten any for several days.

14) The physician order for [redacted] was that he was to be administered 1 tablet of 5mg/325mg Hydrocodone/Acetaminophen (Norco, an opioid, classified as a Schedule II Controlled Substance) by mouth every 6 hours, as needed (PRN) for pain if uncontrolled by Tramadol.

    a) January 6, 2025, Hapner signed out 1 Norco on the CSR at 7:00 a.m. Nothing was documented on the EMAR as administered.
    b) January 6, 2025, Hapner signed out 1 Norco on the CSR at 1:30 p.m. Nothing was documented on the EMAR as administered.
    c) January 8, 2025, Hapner signed out 1 Norco on the CSR at 07:30 a.m. Nothing was documented on the EMAR as administered.

15) When they interviewed Resident [redacted] ("[redacted]"), she said she hadn't received a pain pill on January 8, 2025, because she wasn't hurting. [redacted] said she doesn't take her PRN Hydrocodone/Acetaminophen (Norco) 10mg/325mg every day. She said the last Norco she received was on January 7, 2025, from Dee (QMA DeAngela Underwood).

16) The physician order for [redacted] was that she was to be administered 1 tablet of 10mg/325mg Norco every 4 hours as needed for pain. On January 8, 2025, Hapner signed out 1 Norco on the CSR at 3:30 p.m. Nothing was documented on the EMAR as administered.

17) Waters of LaGrange LPN Lori Miller ("Miller") reported that on January 6, 2025, at approximately 6:15 p.m., during the shift change count of medication cart narcotics with Hapner, they discovered there was a Hydrocodone/Acetaminophen (Norco) 5mg/325mg tablet missing for Resident [redacted] ("[redacted]").

18) There should have been 25 Norco tablets left, but there were only 24. They looked for the missing Norco but were unable to find it. Hapner told Miller she would just write "dropped and wasted" and have one of her supervisors sign off on it later. Miller said when she and Hapner were performing the shift change count, Marble and another supervisor, RN Brooke Richardson, were both in the building. Hapner left without notifying either one of them. Miller refused to sign the CSR and reported the incident to Marble.

19) The physician order for [redacted] was that he was to be administered 1 tablet by mouth of 5mg/325mg Hydrocodone/Acetaminophen (Norco) every 8 hours as needed (PRN) for pain.
    a) On January 6, 2025, Hapner signed out 1 Norco on the CSR at 8:00 a.m. Nothing was documented on the EMAR as administered.
    b) On January 6, 2025, Hapner signed out 1 Norco on the CSR at 1:00 p.m., which was too early, and in violation of the physician order. Nothing was documented on the EMAR as administered.
    c) On January 6, 2025, Hapner documented she dropped and wasted 1 Norco tablet. There was no second signature, as required.
    d) On January 8, 2025, Hapner signed out 1 Norco on the CSR at 10:30 a.m. Nothing was documented on the EMAR as administered.

20) On April 28, 2025, I (Kathy Franko) arranged to meet with and interview Hapner. The interview was recorded, and the recording and interview report were added to the case file.

21) Hapner said she has been an LPN for 25 years and was a Certified Nurse Assistant ("CNA") for 8 years before that. She said she has also held the position of Director of Nursing. Hapner has worked at different types of facilities over the course of her career, including a hospital, a clinic, nursing homes and assisted living facilities. She worked at Waters of LaGrange for 4 months but was not happy there. She said she didn't get any training there. She followed another nurse for 2 days before she was on her own.

22) Hapner said she didn't think she signed off on Waters of LaGrange Policies and Procedures. When I checked her employee file, I found she had signed off on Waters of LaGrange policies on September 25, 2024. I told her by signing off on their policies, she agreed to abide by their rules and regulations.

23) We went over policies and procedures for proper documentation related to medication carts ("carts"), and administering and wasting medications. Hapner said usually she was responsible for one cart, but sometimes she was assigned two carts. Waters of LaGrange doesn't use agency nurses, so they require their QMA's and nurses to work 12 hour shifts. Her normal shifts were 6:00 a.m. to 6:30 p.m. shift, two days in a row. At first, they wanted her to work 3 days at a time, but she told them that was too many days in a row. She asked to work 8 hour shifts, instead of 12, but they denied her request. Hapner said her husband had been in a tragic accident last year and she didn't want to leave him that long.

24) Hapner explained proper procedures for shift-to-shift counting with another nurse, medication cart/key security, and how to sign out narcotics for residents on the CSR. She said nurses were also supposed to enter on the EMAR when they administered a PRN medication, and a progress note and pain score to go with it.

25) Hapner said she always signed out the narcotic on the CSR, but she didn't always enter the administration in the EMAR, or the progress note. I explained to her that signing a medication out on the CSR wasn't administering it. It was just signing the drug out of the cart and into her possession. Hapner admitted that for the PRN medications, she didn't always put it in the EMAR because she got busy or forgot.

26) We discussed proper wasting procedures. She said sometimes a pill can get popped out by mistake and it's hard to find it if there are a lot of other medications in the narcotic box on the cart. I told her she is legally responsible for the medications and documentation when she is in possession of her assigned cart/keys. If not all of the documentation was completed properly, it's a problem.

27) We discussed each of the 4 patients involved in this investigation and I showed her the corresponding documentation (CSR's and EMAR's). Hapner verified her signatures/entries on the CSR's.

28) I pointed out on [redacted] CSR, that she didn't enter 11 of the times she signed out his Oxycodone tablets as administered on the EMAR. Some of the pain scores were 0. I asked why she would administer pain medications if his pain score was 0. She said she may have clicked off on the pain scale at 10:00 a.m. when he was fine, but then later gave him the Oxycodone at 4:30 p.m. when he did have pain, and she forgot to add the new pain score to the PRN administration. I pointed out that she didn't put in any corresponding nursing notes for any of the sign-outs. Hapner said they have in-services all the time where they are reminded to enter the administrations in the EMAR, but she gets busy and forgets.

29) Marble checked to see if Hapner also forgot to document administrations for noncontrolled medications in the EMAR. Marble said she couldn't find that Hapner forgot to enter any of the administrations for noncontrolled medications in the EMAR in December 2024 and January 2025.

30) Hapner said she usually gave [redacted] his PRN Oxycodone when he was in the hallway "smacking somebody". She said other nurses wouldn't give narcotics to him for that. She said the CNA's thanked her and said he was calmer for his showers and not "beating them up." I asked her if she documented that in the progress notes. She said she did a few times. I told her I specifically asked for those notes and Marble told me there weren't any from Hapner in December or January.

31) I told her there were some nursing notes from other nurses in December, but not from her. Marble told me it was unusual for a nurse to give narcotics just to calm a resident down. Marble said other methods should be used first, such as backrubs, etc. Hapner said when she asked Gadson if he was in pain, he told her, "Well what the hell do you think?"

32) Hapner said many nurses are afraid to give patients narcotics because of all the "DEA crap". She said they weren't being a good nurse, because Tylenol doesn't always cut it. Hapner said all four of the residents have dementia. I checked the records and the only resident that had a diagnosis of dementia was [redacted]. Hapner questioned that Marble gave me everything. She said they didn't get along at all and Marble may have not sent or destroyed

some of Hapner's documentation.

33) Hapner questioned the Urine Drug Screen (UDS) and who administered the UDS to [redacted]. I told her [redacted] UDS was done the same day she had signed the Oxycodone out of the CSR on January 8, 2025, at 7:45 a.m. and according to the pharmacy, the Oxycodone should have still been in his system that evening.

34) Hapner said [redacted] had a diagnosis of dementia. I later checked [redacted] records and saw that wasn't true. Hapner insisted [redacted] asked for pain medication during the day and not only at night as he claimed.

35) Hapner talked a lot about her dislike of Marble. Hapner said she offered to take a UDS while she was suspended, but Hunter told her she didn't need to. Hapner said she took a UDS 6 days later and it was fine. Hapner said she didn't usually work [redacted] cart, but [redacted] could have asked her for something, and she gave it to her.

36) Harper stated at shift change, when she and Miller were counting the medication cart together, they discovered [redacted] was missing one Norco tablet. Both Hapner and Miller looked in the cart but couldn't find it. Hapner suggested to Miller that they say the pill was dropped and sign the CSR as wasted.

37) Hapner thought Miller had agreed to sign off on the waste, but then Miller didn't sign it and reported it to Marble. I told her Miller did the right thing. Hapner said she has done it that way over the years for other nurses, because that happens. I pointed out to Hapner she had signed the Norco was wasted at 13:00 (1:00 p.m.). At that time, their supervisors were right down the hall. Hapner said she would have counted at 6:00 p.m. but put 1:00 p.m. because that's when she thought she might have dropped it, when she gave Dickmeyer the PRN Norco. She said she backdated when she thought it might have happened.

38) We discussed that she is prescribed 60 Tramadol per month. She said she has fibromyalgia and rheumatoid arthritis. She said she is supposed to take one tablet every 12 hours, but she usually just takes two tablets at bedtime. I suggested maybe the Tramadol wasn't working anymore for her since she'd been on it a long time, or she had built up a tolerance, and needed something stronger. She insisted she didn't steal the narcotics from Waters of LaGrange and was only guilty of being overworked and not documenting properly.

39) My investigation revealed that between November 3, 2024, and January 8, 2025, on at least one occasion, Sheri Hapner did recklessly, knowingly or intentionally fail to make, keep or furnish a record as required under I.C. 35-48 as to the documentation of the dispensing or administration of controlled substances, in violation of I.C. 35-43-4-2(a)(3).

40) My investigation revealed that on January 6, 2025, Sheri Hapner knowingly or intentionally furnished false or fraudulent material information in or omitted material information from a report or other document required to be kept or filed under I.C. 35-48 as to the documentation of the dispensing or administration of controlled substances in violation of I.C. 35-48-4-14(b)(3).

41) My investigation revealed that between November 3, 2024, and January 8, 2025, on at least one occasion, Sheri Hapner knowingly or intentionally acquired possession of a controlled substance; to wit: Norco (hydrocodone/acetaminophen) and Oxycodone, both Schedule II Controlled Substances 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/ Kathy A. Franko
Affiant, Kathy A. Franko
Diversion Investigator
Medicaid Fraud Control Unit