IN THE HAMILTON CIRCUIT/SUPERIOR COURTS

STATE OF INDIANA)
) SS:
COUNTY OF HAMILTON)

CAUSE NO. 29

THE STATE OF INDIANA

VS.

TAMARA SMART
[redacted]

OLN: [redacted]
DOB: [redacted]
SSN: [redacted]

PHYSICAL DESCRIPTION
Race: W Sex: Female
Height: 5'07" Weight: 200
Eyes: Brown Hair: Brown

INFORMATION FOR:

Count 1:
Obtaining a Controlled Substance by Fraud or Deceit
I.C. 35-48-4-14(c)
a Level 6 Felony

Count 2:
Failure to Make, Keep or Furnish Records
I.C. 35-48-4-14(a)(3)
a Level 6 Felony

BE IT REMEMBERED,

That on this day comes the undersigned Deputy Attorney General of the Office of Indiana Attorney General Todd Rokita who alleges that in the County of Hamilton, State of Indiana,

Count 1: between April 2, 2025 and August 19, 2025 Tamara Smart did knowingly or intentionally acquire possession of a controlled substance, to-wit: Oxycodone by misrepresentation, fraud, forgery, deception, and/or subterfuge.

Count 2: between April 2, 2025 and August 19, 2025 Tamara Smart did recklessly, knowingly or intentionally fail to make, keep and/or furnish a record as required by I.C. 35-48.

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

Submitted this day, June 10, 2026

/s/ Kyle Sprunger
Deputy Attorney General
Attorney No. 37755-29

STATE OF INDIANA VS. TAMARA SMART

Craig Whited
Mackenzie McCallister
Yolanda Moore
Patricia Nicholas-Freeman
Jimella Robinson

Agency case # Not Available

STATE OF INDIANA) **IN THE HAMILTON SUPERIOR COURT**

) **SS:**

COUNTY OF HAMILTON) **CAUSE NO:**

STATE OF INDIANA)

)

VS.)

)

Tamara S. Smart)

DOB: 10-09-1974

AFFIDAVIT FOR PROBABLE CAUSE

I, Craig Whited, a Drug Diversion Investigator for the Indiana Office of Attorney General, Medicaid Fraud Control Unit, have probable cause to believe that Tamara Smart did commit the following crimes in the County of Hamilton, State of Indiana:

I.C. 35-48-4-14(c) – Obtaining a Controlled Substance by Fraud – a Level 6 Felony
I.C. 35-48-4-14(a)(3) – Failure to Make, Keep, or Furnish 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 Wellbrooke of Carmel and medical records related to this investigation. I believe these witnesses to be truthful and credible.

2. Because this affidavit is being submitted for the purpose 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. On 08-22-2025 Wellbrooke of Carmel (hereafter referred to as "Wellbrooke") reported to the State of Indiana that a licensed practical nurse named Tamara Smart had been suspended after irregularities were found in the Controlled Substance Records for oxycodone for two different Wellbrooke residents. This complaint was later assigned to this Investigator.

4. Tamara Smart is a Licensed Practical Nurse (LPN) with the nursing license number of 27056278A. LPN Tamara Smart also has the date of birth of [redacted] and a home address of [redacted], [redacted].

5. LPN Tamara Smart was employed at Wellbrooke as an LPN from 12-21-2021 until she resigned on 08-28-2025 while she was 'suspended pending investigation' from Wellbrooke.

6. Wellbrooke is a long-term care facility (nursing home) that has skilled nursing, assisted living, and memory care. Residents typically live there because they have chronic conditions that require 24-hour care and supervision. Wellbrooke is located at 12315 North Pennsylvania Street, Carmel, IN, 46032, in Hamilton County.

7. Wellbrooke 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, IC 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 such as 856 IAC 1-28.1-12. Title 21 United States Code (USC) 827(a)(3) and Title 21 Code of Federal Regulations (CFR) 1304.22 (21 CFR § 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 Regulation 21 CFR §1304.22 and 21 CFR §1317.95 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.

8. Wellbrooke utilizes Synchrony Pharmacy Indianapolis to provide pharmacy services to their facility; and Wellbrooke receives regular deliveries of medication, including controlled substance medications, in the form of daily deliveries from Synchrony Pharmacy Indianapolis.

9. Wellbrooke utilizes locked Medication Carts (“Med Carts”) to store and dispense medications to residents within their facility. A Med Cart will be assigned to a group of residents, and that Med Cart will contain medications that are prescribed to the residents that Med Cart is assigned to. These Med Carts are locked and require a key to unlock it in order to access the medications within that cart.

10. Wellbrooke then utilizes nurses to administer the medications within a Med Cart to the facility residents that the medications are prescribed to. Each shift, a nurse will be assigned a specific locked Med Cart and will be the only staff member on the floor that will have the keys to unlock their assigned Med Cart to access the medications within it. For example: While on duty, LPN Tamara Smart would be the only staff member on the floor that would have the keys to unlock her assigned Med Cart in order to access oxycodone and other medications inside of it.

11. Nurses that are assigned to a Med Cart will unlock it to access the medications, withdraw the medications for the appropriate resident per physician order, and then make the appropriate records that note the medication was removed from the Med Cart and then administered to the patient.

12. When a nurse that is assigned to a Med Cart begins their shift, they will do an inventory count of the controlled substance medication inside of the Med Cart with the outgoing nurse they are relieving. This is many times called a “shift-change count.” This count, conducted by the incoming and outgoing nurses together, helps to ensure the inventory of medications is correct. Once the controlled substance medications have been counted together, the incoming nurse takes control of the Med Cart and its keys from the outgoing nurse, and the incoming nurse now has the keys to unlock the Med Cart until that nurse ends their shift and does another medication count with the new incoming nurse that is relieving them.

13. Wellbrooke’s policy is that when a nurse withdraws a controlled substance medication from their assigned Med Cart, that assigned nurse will sign and date a paper Controlled Drug Use Record that shows the date, time, and amount (dose) of the medication they withdrew from the Med Cart to be given to a facility resident. Many nurses will often refer to the Controlled Drug Use Record as ‘narcotic count sheets’ or ‘narc count sheets,’ etc.

14. When a nurse signs and dates that they withdrew a dose of a controlled substance medication on the Controlled Drug Use Record, it shows that the nurse removed one of the doses from the Med Cart. This assists in keeping a running inventory/count of the remaining controlled substances that should still be left inside the Med Cart, along with the signed name of the staff member who withdrew the controlled substance medications. For the purposes of this investigation: every time that LPN Tamara Smart removed a dose of oxycodone from the Med Cart, she was required to sign and date on the Controlled Drug Use Record for that oxycodone to show the date & time she removed that dose.

15. When medication is given to the patient, the nurse must also complete an entry into the facility’s electronic Medication Administration Record (eMAR or MAR) to show that they administered the medication to the resident. The MAR shows which medication, the dosage, date, and what time of day the

medication was given to the resident. The MAR also records the date/time/quantity and reason for giving a patient medication and shows which nurse administered it, and the nurse's initials will appear in the MAR as showing that the nurse administered the medication to the resident. For the purposes of this investigation: LPN Tamara Smart's initials in the MARs appear as "TSS" for "Tamara Sue Smart."

16. Wellbrooke utilizes a computer program called "MatrixCare" for staff members to electronically chart the medical care they give to facility residents. In MatrixCare, both the regular medications and controlled substance medications are listed in the residents' profile on the computer program. Therefore, when a nurse charts the administration of medication to a resident, they will electronically chart in MatrixCare their administration of both regular medications and controlled substance medications to the facility's residents.

17. The Controlled Drug Use Record and the MAR serve as the official records of the medications administered to a patient and are part of the patient's permanent medical record. The employee is required to complete these records each time a drug is removed and/or administered to a patient. It is vital for patient safety to document the administration of a drug on the MAR, so that physicians and other service providers can make informed decisions about the care of the patient, and to prevent accidental overdoses.

18. [redacted] is a 71-year-old resident of Wellbrooke and is prescribed Oxycodone/APAP 5-325mg tablets as a 'PRN as-needed' pain killer, which means that she needs to request a dose before one is given to her. [redacted] is one of the two residents that had irregularities with her oxycodone's Controlled Substance Records involving LPN Tamara Smart. Oxycodone is a controlled substance and a narcotic pain-reliever and is classified as a Schedule II drug.

19. [redacted] is a resident of Wellbrooke and is prescribed Oxycodone 5mg tablets, also as a 'PRN as-needed' pain killer. [redacted] can take her oxycodone once daily as needed for pain. [redacted], along with [redacted], had irregularities with their oxycodone's Controlled Drug Use Record involving LPN Tamara Smart.

20. On 08-19-2025 LPN Tamara Smart began her overnight shift at Wellbrooke, where from 6pm to 10pm she was assigned to the facility's Keystone Unit and its Med Cart from 6pm to 10pm.

21. At 10pm Charge Nurse Yolanda Moore noticed that LPN Tamara Smart appeared to be tired, so Charge Nurse Moore relieved LPN Tamara Smart from the Keystone Unit and its Med Cart and directed LPN Tamara Smart to go to the Berkshire Unit where it would be quieter.

22. When Charge Nurse Yolanda Moore relieved LPN Tamara Smart from the Keystone Unit and its Med Cart, Charge Nurse Moore directed LPN Smart to go get 'report' from the nurse at the Berkshire Unit, but then return so she (Moore) and LPN Smart could do the shift-change medication inventory count of the narcotic medications inside the Keystone Unit's Med Cart. However, they became busy and LPN Smart never returned to do the medication count.

23. The next morning (08-20-2025) at 6am RN Patricia Nicholas-Freeman began her shift and began doing the shift-change medication inventory count of the narcotic medications inside the Keystone Unit's Med Cart with Charge Nurse Yoland Moore. During this count they noticed that there were fewer doses of narcotic medications inside the Med Cart than what the Controlled Drug Use Record showed there should be. Charge Nurse Moore then explained to RN Nicholas-Freeman that LPN Tamara Smart was assigned to the Med Cart the evening before, and the missing narcotic medications would have been withdrawn from the Med Cart by LPN Tamara Smart.

24. Upon RN Patricia Nicholas-Freeman finding there were missing narcotic medications, RN Nicholas-Freeman then went to the Berkshire Unit and requested LPN Tamara Smart to return to the Keystone Unit's Med Cart so they could do the medication inventory count to reconcile the missing medications.

25. When RN Nicholas-Freeman and LPN Tamara Smart did this medication inventory count to reconcile the missing narcotic medications, RN Nicholas-Freeman would physically count the narcotic medications and verbally give the number of doses remaining inside the Med Cart, and then LPN Tamara Smart would sign the Controlled Drug Use Records when they came across a discrepancy. By LPN Smart signing the Controlled Drug Use Record with the date and time that she (Smart) reportedly withdrew a dose, this would cause the Controlled Drug Use Record to match the number of remaining doses in the Med Cart and thus would rectify the discrepancies. LPN Tamara Smart told RN Nicholas-Freeman that the reason why she did not sign the narcotic medications out correctly was because she (Smart) was sick.

26. On 08-22-2025 HFA Carmack interviewed LPN Tamara Smart about her discrepancies of the narcotic medications and also appearing impaired on duty. During this interview, LPN Tamara Smart denied that she was impaired and denied diverting oxycodone, but she admitted to HFA Carmack that the signatures on the Controlled Drug Use Records for [redacted] and [redacted] oxycodone were her (Smart's) signatures. She was then 'suspended pending investigation,' but LPN Smart resigned via email on 08-28-2025.

27. When HFA Carmack reviewed the Controlled Drug Use Record for [redacted] oxycodone-acetaminophen 5 mg-325 mg tablet that was delivered on 03-28-2025, she observed 11 instances where LPN Tamara Smart had signed that she had withdrew a dose of the oxycodone but failed to chart in the MAR that she had administered it to [redacted]. Below is the list of dates and times that LPN Tamara Smart signed that she withdrew doses of oxycodone for [redacted] but failed to chart what she did with the doses:

1. 04-02-2025 at 10pm
2. 05-16-2025 at 6pm
3. 05-27-2025 at 8pm
4. 05-28-2025 at 4am
5. 05-29-2025 at 11pm
6. 05-31-2025 at 11:30pm
7. 06-01-2025 at 11pm
8. 06-04-2025 at 11pm
9. 06-07-2025 at 8pm
10. 08-15-2025 1:15am
11. 08-19-2025 11pm

28. Further into this investigation, this Investigator learned that LPN Tamara Smart was OFF DUTY on 05-29-2025 at 11pm when LPN Smart signed and dated that she withdrew a dose of oxycodone for [redacted].

29. When HFA Carmack reviewed the Controlled Drug Use Record for [redacted] oxycodone 5mg tablets that were delivered on 06-29-2025 she observed 5 instances where LPN Tamara Smart had signed that she had withdrawn a dose of the oxycodone but failed to chart in the MAR that she had administered it to [redacted]. Below is the list of dates and times that LPN Tamara Smart signed that she withdrew doses of oxycodone for [redacted] but failed to chart what she did with the doses:

1. 07-23-2025 at 12:25am
2. 07-24-2025 at 12am
3. 07-27-2025 at 8pm
4. 08-06-2025 at 9pm
5. 08-19-2025 at 9:30pm

30. On 11-19-2025 this Investigator conducted an interview with LPN Tamara Smart. Since LPN Tamara Smart had never met this Investigator before, I offered to meet her at the Cumberland Police Department, and she agreed and she drove herself to the interview. The Cumberland Police Department was also selected because it was close to LPN Tamara Smart's home, and we could talk without violating HIPAA.

31. During this interview LPN Tamara Smart confirmed that her date of birth is [redacted], and that she used to work at the Wellbrooke of Carmel located 12315 North Pennsylvania Street in Carmel from 12-21-2021 until late August of 2025, and that she has been a nurse for 20 years.

32. When this Investigator asked LPN Tamara Smart about the report that she may have been impaired while on duty on her last shift at Wellbrooke, LPN Smart denied that she was impaired and stated it was because she had worked the overnight shift with only having received 2 ½ to 3 hours of sleep. She also stated that she normally only takes 1 dose of her prescribed Tizanidine (a muscle relaxer) before work, but because she was so tired she accidentally took a 2nd dose, along with a dose of prescribed Xanax and Buspar (an anti-anxiety drug), about an hour before she started her shift. She believes the Xanax and the 2 doses of Tizanidine, combined with little sleep, made her sleepy on her last shift at Wellbrooke.

33. When this Investigator asked LPN Tamara Smart what the proper procedure was for withdrawing and administering a controlled substance medication like oxycodone was, LPN Tamara Smart answered:

a. The pain meds are stored in the Med Cart and only the nurse that's assigned to that Med Cart

has the key to unlock the Med Cart.

b. When a patient asks for a pain med, she first assesses the patient's pain.

c. She then checks the Controlled Substance Record and MAR to ensure the patient is prescribed the medication and to ensure that another nurse hasn't recently given a dose to the patient.

d. She signs & dates & time on the "Narc Count Sheet" (Controlled Drug Use Record) that she removed a dose. This keeps track and an inventory of the narcotic medications.

c. She then administers the dose to the patient and then charts in the MAR that she gave the dose.

d. She then later does a follow-up on the patient's pain level and charts that also.

e. It is important to chart the administration of pain pills to a patient in the MAR for regular assessments, and it also allows the next nurse to see when the patient had a last dose. This prevents overdoses.

34. When this Investigator asked LPN Tamara Smart why there were 11 instances where she signed that she withdrew doses of oxycodone on [redacted] Controlled Drug Use Record for oxycodone dated 03-28-2025 and 5 instances that she withdrew doses of oxycodone on [redacted] Controlled Drug Use Record for oxycodone dated 06-29-2025, LPN Tamara Smart stated:

a. The signatures on the Controlled Substance Record that are highlighted are her signatures.

b. She must have forgotten to chart the administrations if it was a busy night.

c. Nurses cannot chart the administration of medications at a later time, because then the computer system won't let the next nurse chart an administration if it would be within the time window that a resident couldn't have a dose.

d. Her (LPN Smart's) 'sign-in' on the MARs is "TSS2."

35. When this Investigator asked LPN Tamara Smart about the discrepancies with controlled substances at the end of her last shift where RN Patricia Nicholas-Freeman had to get her to sign out controlled substance medications that she (LPN Smart) had withdrew from the Med Cart but had failed to sign them out on the Controlled Drug Use Record, LPN Tamara Smart stated:

a. She was extremely tired that shift.

b. She did not do a shift-change medication inventory count with Charge Nurse Yolanda Moore when Yolanda relieved her from the Med Cart and sent her to the Berkshire Unit.

c. When RN Patricia Nicholas-Freeman came and got her, she (LPN Smart) came back and signed out the missing controlled substance medications.

d. She had failed to sign out some of the controlled substance medications when she withdrew them from the Med Cart.

36. When this Investigator asked LPN Tamara Smart how she could withdraw a dose of oxycodone for [redacted] on 05-29-2025 at 11pm when she was off work that day, LPN Smart stated that she must have messed up her time records because overnight shifts turn into a '2nd day.' However, when this Investigator reviewed the Wellbrooke time records for LPN Smart, I observed that she was not at work on 05-29-2025 at 11pm. She had gotten off work at 6:30am on 05-29-2025 and she did not return back to work for two days until 05-31-2025 at 6pm.

37. This investigation reveals that on at least one occasion between 04-02-2025 and 08-19-2025 Tamara Smart knowingly or intentionally acquired possession of a controlled substance; to wit: oxycodone, by misrepresentation, fraud, forgery, deception, subterfuge, or concealment of a material fact in violation of I.C. 35-48-4-14(c).

38. This investigation reveals that on at least one occasion between 04-02-2025 and 08-19-2025 Tamara Smart did recklessly, knowingly or intentionally fail to make, keep or furnish a record, a notification, an

order form, a statement, an invoice, or information required 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(a)(3).

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/Craig Whited
Affiant, Craig Whited
Drug Diversion Investigator