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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

Appeal from Orangeburg County
Court of Common Pleas

Maité Murphy, Circuit Court Judge

Case No. 2022-CP-38-00525
Appellate Case No. 2025-000296

Beverly Vaughn,
as Personal Representative of the Estate of Loris Paris,

Respondent,

v.

Saint Matthews Healthcare, LLC; Melissa Kizer;
Melissa Davis; and Angela Smith Teliha,

Defendants,

Of which Saint Matthews Healthcare, LLC;
Melissa Kizer; and Melissa Davis, are the

Appellants.

SUPPLEMENTAL RECORD ON APPEAL

CANTWELL LAW FIRM, LLC
Joshua P. Cantwell (SC Bar No. 76368)
P.O. Box 600
Charleston, South Carolina 29402
(843) 801-4104

Attorney for Respondent

CLEMENT RIVERS, LLP
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Charleston, South Carolina 29401
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(843) 720-5488

Attorneys for Appellants

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Other Material

ELECTRONICALLY FILED - 2024 Feb 06 10:05 AM - ORANGEBURG - COMMON PLEAS - CASE#2022CP3800525

Healthy Connections MEDICAID

Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

Name of Medicaid applicant/member	Social Security Number

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your case?

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an "authorized representative." The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

Name of Authorized Representative (First name, Middle name, Last name)	☐ New ☐ Change ☐ Addition ☐ Remove this person or organization as my authorized representative
Authorized Representative's address (Leave blank if you don't have one.)	Apartment or suite number
City / State / ZIP code	
Authorized Representative's phone number / Other phone number	
Authorized Representative's email address	
Organization name (If applicable) / Unit* (If applicable) / ID number (If applicable)	

*It is best to identify a specific unit for large organizations.

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application?

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization	Phone
Cindy Bozard / Colleton Convalescent Center	803-655-7101
Address: 1001 Doctor St. / City: St. Matthews / State: SC / ZIP: 29135	
Unit (If applicable) / ID Number (If applicable)	

X Medicaid applicant/member's signature: Bunky Vaughn — Date (mm/dd/yyyy): 2/11/19

If signing with an "X," please have two people sign below as witnesses.

Witness:_____ Witness:_____

☐ Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member's inability to sign. Provide reason:

Mail your signed form to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 **Fax:** (888) 820-1204

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-753-8583.

SOUTH CAROLINA COMMUNITY LONG TERM CARE

CONSENT FORM

Client Name: Lori Paris

Social Security Number: [redacted]

I understand as part of my application for long term care services in the community or a Title XIX nursing home, my condition must be evaluated by the South Carolina Community Long Term Care Program.

This evaluation includes information provided by:

a. my physician and medical records;
b. professionals and organizations involved with my care; and,
c. an interview with me and, if necessary, with my family.

I hereby authorize any social service professionals, organizations, doctors, nurses, or other medical personnel or medical facilities involved in my care to release to Community Long Term Care any medical information regarding my diagnoses and recommended treatment.

I hereby authorize Community Long Term Care to release information on my behalf to physicians, hospitals, health and human service organizations, health and human service agencies, family members and/or other persons directly involved with my care.

I understand if my current or future diagnosis includes Alzheimer's Disease, senile dementia or a similar disorder, my records may be reviewed by the statewide Alzheimer's Disease and Related Disorders Registry, and I, or my responsible party, may be contacted for additional information.

Use the space below to indicate the name of any organization, agency or person to whom you do not choose to release information.

This consent shall remain in effect until _____, revoked by me in writing, or until such time as my case is closed by Community Long Term Care.

Date: 4/11/19 X Beverly Vaughn

Signature of Client or Responsible Party

If Signed by Responsible Party, State Relationship and Authority to Sign.

Date: _____ *Signature of Witness*

DHHS Form 121 (Revised 10/02)

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COMMUNITY LONG TERM CARE
CLIENT SERVICE CHOICE

Client Name:	CLTC #:

Choice of Location of Services

I choose to have my long term care services provided:

[ ] In Community

[ ] In Nursing Home

I understand that at some future date I may change my choice for location of care. If this occurs, I will contact my Community Long Term Care worker and sign a new Client Service Choice Form.

Choice of Participation in Community Case Management

[ ] I choose to participate in a Medicaid home and community-based waiver program.

[ ] I do not choose to participate in a Medicaid home and community-based waiver program.

Comments:

Client/Responsible Party: X Beverly Vaughn	Date:
CLTC Worker:	Date:

HHS Form 164 (Feb 95) Edition 2/90 is obsolete.

ACKNOWLEDGEMENT - PROTECTION OF RESIDENT FUNDS
(This form to be used by Business Office ONLY)

Deposit of Personal Funds: By my signature and mark below, I have indicated my wishes/authorization for the deposit of personal funds with the Facility. I understand that I can amend this wish/authorization at any time by notifying the Facility in writing.

☐ _____ (initial) I do not wish to deposit personal funds with the Facility at this time.

or

☐ _____ (initial) I authorize the Facility to accept, hold and account for my personal funds in accordance with the policies outlined herein. I acknowledge that I have the right to revoke this authorization at any time upon written notice to the Facility. I acknowledge that authorized State agencies may audit this account, regardless of my payer source.

x Beverly Vaughn _____ Beverley Vaughn
Resident/Representative Signature Date Printed Name/Relationship to Resident

_____ _____
Witness Signature Date Printed Name

_____
Resident Signature Date

_____ _____
Witness Signature Date Printed Name

_____ _____
Facility Representative Date Printed Name/Title

Original: Business File • Photocopy: Resident/Representative

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RESIDENT FUND ACCOUNT AUTHORIZATION

RESIDENT'S NAME _____

This is to authorize Calhoun Convalescent Center to make deposits and withdrawals from the Resident Fund Account of the above named Resident as follows:

Please designate which of the below are authorized by the word **"YES"** or **"NO"**.

1. _____ Beauty Shop
2. _____ Pharmacy Bills
3. _____ Ambulance Service
4. _____ Personal Shopping
5. _____ Room and Board
6. _____ Other

In addition to the above, by executing the form, Resident and Responsible Party, if any, authorize the Facility to withdraw from Resident's Account such amounts, with such degree of frequency, so as to insure that at all times those monies owed the Facility by the resident are paid in a timely fashion. Resident will be provided a Quarterly Report as to all transactions which have occurred. Furthermore, Resident may request an Accounting at any time.

This authorization (approval) shall remain in effect until revoked in writing by Resident and Resident's Responsible Party, if any. Until revocation, it shall be binding upon Resident, his Responsible Party, if any, and upon his/her heirs and assigns.

Date_____ _____
Resident Signature

APPROVED: X Brenda Vaughn
Responsible Party Signature

_____
Facility Representative

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MEDICARE SCREENING QUESTIONNAIRE

PART VI – ESRD

1. Do you have group health plan (GHP) coverage?

☐ Yes **IF APPLICABLE, YOUR GHP INFORMATION**

Name and address of GHP: _____ Name and address of employer GHP coverage received from: _____

Relationship to Patient: _____ Policy/Membership ID #: _____

Name of Policyholder/insured: _____ Group ID #: _____

IF APPLICABLE, YOUR SPOUSE'S / FAMILY MEMBER'S GHP INFORMATION

Name and address of GHP: _____ Name and address of employer GHP coverage received from: _____

Relationship to Patient: _____ Policy/Membership ID #: _____

Name of Policyholder/insured: _____ Group ID #: _____

2. Have you received a kidney transplant?

☐ Yes Date of Transplant: _____ ☐ No

3. Have you received maintenance dialysis treatments?

☐ Yes Date Dialysis Began: _____

If you participated in a self-dialysis training program, provide date training started: _____

☐ No

4. Are you within the 30-month coordination period that starts ___/___/___? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the firth month of dialysis). If the individual is participating in a self dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

☐ Yes ☐ No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and Age or ESRD and Disability?

☐ Yes ☐ No

6. Was your initial entitlement to Medicare *(including simultaneous or dual entitlement)* based on ESRD?

☐ Yes **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

☐ No **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP *already primary* based on age or disability entitlement)?

☐ Yes **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

☐ No **MEDICARE CONTINUES TO PAY PRIMARY.**

X Emily Vaughan 7/11/19

Beneficiary or Representative Signature Date

Name of person assisting in the completion of this form: _____

Title: _____

Calhoun Convalescent Center
ADMISSION SIGNATURE DOCUMENT

RESIDENT TRANSFER - It is the policy of this facility that a three (3) day notice is to be given if planning to transfer a Resident to another facility or to home. This notice will enable the facility to gather all medical information needed for transfer or discharge as well as allow time to prepare the resident for this move. All financial matters must be completed during this time.

RESIDENT DIAGNOSIS - I understand that I have been told of my medical diagnosis, prognosis, and plan of care and treatment. I or my representative may attend Care Plan Meetings. You will receive a call for the first meeting and mail letters to request attendance. The first care plan meeting will be within 3 weeks of admission then quarterly.

GRIEVANCE PROCEDURES - I understand that I understand the Grievance Policies and Procedures of this facility and have been advised of address and telephone numbers of Regulatory Agencies I may contact. All grievances should be directed to the social director to follow protocol.

RESIDENT FUND - I request the facility to maintain my personal funds in the Resident Fund Account. I understand that I will be given an accounting of the funds each quarter for billing purposes. Resident funds are available 7 days a week, week days at the front office and weekends and or holidays at the East Wing Nurses Desk.

PERSONAL LAUNDRY - I understand that it is our policy to have no iron's or heated devices in the facility for safety purposes. All clothing should be machine washable. No dry clean only clothing is allowed.

I understand it is my responsibility to remove all seasonal clothing from facility. We cannot hold any clothing for seasons and all clothing and items should be able to fit in the closets and drawers provided. Please check frequently and remove as needed. Any clothing brought in after admission must be labeled by laundry and added to the inventory list at the back of your resident's chart.

TELEPHONE

A public phone for resident use is available in the front lobby . If you wish to have a private phon, telephone installation, charge and monthly bills are the sole responsibility of the resident or responsible party. Telephone setup can be made with Windstream 1-800-347-1991.

VISITING HOURS

Visitors are welcome at anytime to this facility. We ask that family members use their best judgment and visit at responsible hours. We reserve the right to put restrictions on visitations according to the medical condition of the resident as well as specific orders from our medical staff.

AUTHORIZATION:

X Beverly Vaughn — 4/11/19

Responsible Party /Resident — Date

Facility Representative — Date

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ATTACH ORIGINAL SIGNED COPY WHEN RECEIVED

1 **PHYSICIAN/PRESCRIBER PLEASE SIGN AND RETURN**

☐ Send NO MEDS ☐ Send ALL MEDS ☐ Send ★ MEDS ONLY ☐ ___ Doses taken from Emergency/Backup Stock ☐ When available/next routine delivery: ☐ Stat ☐

ORIGINAL COPY

Facility Name CCC | Address | Signature of Nurse Receiving Order | Date/Time

Family Name Paris | First Name Lons | DOB 9/12/38 | Admission Number [redacted] | Room Number | Attending Physician Dr Jester

Telephone Orders

Date Ordered	Time Ordered	Date D/C'd	MEDICATION/Order	Dose & Form	Route	Schedule	INDICATION - DX
			DNR				
			Signature Becky Vaughn				

Physician/Prescriber Signature | Title | Date | ☐ Resident ☐ Family has been notified of the above treatment change. Date notified ___/___/___ Name of person contacted ___ If not contacted, reason ___

NURSE: Please Initial The Documentation Record As Performed

Pharmacy ☐ Courier ☐ Faxed (Fax Original) ☐ Phone	On Physician's Order Sheet	Med Sheet	TX Sheet	Nurse's Notes	Patient Care Plan	ADL/Flow	Signed	Date	Time

2 **PHYSICIAN/PRESCRIBER PLEASE SIGN AND RETURN**

☐ Send NO MEDS ☐ Send ALL MEDS ☐ Send ★ MEDS ONLY ☐ ___ Doses taken from Emergency/Backup Stock ☐ When available/next routine delivery: ☐ Stat ☐

ORIGINAL COPY

Facility Name | Address | Signature of Nurse Receiving Order | Date/Time

Family Name | First Name | DOB | Admission Number | Room Number | Attending Physician

Telephone Orders

Date Ordered	Time Ordered	Date D/C'd	MEDICATION/Order	Dose & Form	Route	Schedule	INDICATION - DX

Physician/Prescriber Signature | Title | Date | ☐ Resident ☐ Family has been notified of the above treatment change. Date notified ___/___/___ Name of person contacted ___ If not contacted, reason ___

NURSE: Please Initial The Documentation Record As Performed

Pharmacy ☐ Courier ☐ Faxed (Fax Original) ☐ Phone	On Physician's Order Sheet	Med Sheet	TX Sheet	Nurse's Notes	Patient Care Plan	ADL/Flow	Signed	Date	Time

3 **PHYSICIAN/PRESCRIBER PLEASE SIGN AND RETURN**

☐ Send NO MEDS ☐ Send ALL MEDS ☐ Send ★ MEDS ONLY ☐ ___ Doses taken from Emergency/Backup Stock ☐ When available/next routine delivery: ☐ Stat ☐

ORIGINAL COPY

Facility Name | Address | Signature of Nurse Receiving Order | Date/Time

Family Name | First Name | DOB | Admission Number | Room Number | Attending Physician

Telephone Orders

Date Ordered	Time Ordered	Date D/C'd	MEDICATION/Order	Dose & Form	Route	Schedule	INDICATION - DX

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Pharmacy ☐ Courier ☐ Faxed (Fax Original) ☐ Phone	On Physician's Order Sheet	Med Sheet	TX Sheet	Nurse's Notes	Patient Care Plan	ADL/Flow	Signed	Date	Ti

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Form # MP5013 (Rev. 04/09)

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CONSENT FOR THE RELEASE OF MEDICAL RECORDS

NOTE: This form is to be used only when the facility needs to request a patient's/resident's medical records from another health care provider. This form does NOT authorize the facility to release a patient's/resident's medical record.

Patient/Resident Name Lois Paris
Medicare No. [redacted]
Provider Dr Leo Jesion
Social Security No. [redacted]
Service Dates: From _____ To _____
DOB: 9/12/1938

By my signature below, I hereby authorize and request Provider to release the following information contained in the medical/financial record of: Lois Paris ("Patient/Resident") to Calhoun Convalescent Center ("Facility"). I understand these records will be made a permanent part of Patient's/Resident's medical record currently at Facility and that the information will be used for purposes of Patient's/Resident's continued treatment and care at Facility.

Information to be disclosed shall include:

[ ]	complete record	[ ]	history and physical
[ ]	abstract	[ ]	progress notes
[ ]	clinical resume	[ ]	emergency/urgent care
[ ]	consultation reports	[ ]	procedures: operative/anesthetic
[ ]	therapy record	[ ]	discharge summary
[ ]	lab/x-ray/diagnostic results	[ ]	other _____

I understand that this medical record may include information concerning psychiatric diagnoses, drug abuse, alcoholism or communicable or venereal diseases (including but not limited to diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ["AIDS"]). **With this knowledge, I hereby give my consent to release the requested information from Patient's/Resident's medical record, including any information concerning Patient's/Resident's identity.**

I understand that Provider will not condition Patient's/Resident's continued treatment, payment, enrollment or eligibility for benefits on my signing this authorization and that I may revoke this authorization at any time by notifying Provider in writing, except to the extent that action has been taken in reliance on this authorization prior to the revocation. I further understand that the Facility is bound by federal privacy regulations, and that the information described above may not be re-disclosed by them without proper authorization.

This authorization shall expire on _____ OR Upon discharge (event).
(If no expiration date or event, this authorization will expire six (6) months from the date on which it was signed.)

Signed By:
X Beverly Vaughan
Patient/Resident OR Legal Representative
on 4/11/19 (date)

Original: Medical Chart • Photocopy: Resident/Representative

FFUS107 Release of Medical Records (Rev. 6/2009)

CALHOUN CONVALESCENT CENTER

Acknowledgement of Mechanical Lift Policy & Procedures

This Facility Operated Under a Mechanical Lift Workplace Program

THIS PROGRAM HAS BEEN IMPLEMENTED IN AN EFFORT TO PROVIDE A SAFE AND HEALTHY ENVIRONMENT FOR INDIVIDUALS IN OUR CARE AND OUR EMPLOYEES.

THE TOTAL MECHANICAL LIFT WILL BE USED FOR INDIVIDUALS WHO CANNOT BEAR WEIGHT ON THIR LEGS AND CAN OFFER ONLY MINIMAL ASSISTANCE WITH THEIR TRANSFERS AND/OR LIFTS.

THF SIT TO STAND LIFT WILL BE USED FOR INDIVIDUALS WHO CAN BEAR WEIGHT ON THEIR LEGS AND CAN OFFER ASSISTANCE WITH THEIR TRANSFERS AND/OR LIFTS.

A LIFT WILL NOT BE USED FOR INDIVIDUALS WHO CAN ASSIST GREATER THAN 50% WITH THEIR TRANSFER AND/OR LIFTS IN ORDER TO CONTINUE TO PROMOTE THEIR HIGHEST LEVEL OF FUNCTIONING.

I have read and understand the Mechanical Lift Policy and Procedures.

x Beverly Vaughn
Resident/Representative Signature Date

x Beverley Vaughn
Printed Name of Resident/Representative

Authorized Agent of Facility Date

Printed Name & Title

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Calhoun Convalescent Center
ADMISSION SIGNATURE DOCUMENT

RESIDENT TRANSFER - It is the policy of this facility that a three (3) day notice is to be given if planning to transfer a Resident to another facility or to home. This notice will enable the facility to gather all medical information needed for transfer or discharge as well as allow time to prepare the resident for this move. All financial matters must be completed during this time.

RESIDENT DIAGNOSIS - I understand that I have been told of my medical diagnosis, prognosis, and plan of care and treatment. I or my representative may attend Care Plan Meetings. You will receive a call for the first meeting and mail letters to request attendance. The first care plan meeting will be within 3 weeks of admission then quarterly.

GRIEVANCE PROCEDURES - I understand that I understand the Grievance Policies and Procedures of this facility and have been advised of address and telephone numbers of Regulatory Agencies I may contact. All grievances should be directed to the social director to follow protocol.

RESIDENT FUND - I request the facility to maintain my personal funds in the Resident Fund Account. I understand that I will be given an accounting of the funds each quarter for billing purposes. Resident funds are available 7 days a week, week days at the front office and weekends and or holidays at the East Wing Nurses Desk.

PERSONAL LAUNDRY - I understand that it is our policy to have no iron's or heated devices in the facility for safety purposes. All clothing should be machine washable. No dry clean only clothing is allowed.

I understand it is my responsibility to remove all seasonal clothing from facility. We cannot hold any clothing for seasons and all clothing and items should be able to fit in the closets and drawers provided. Please check frequently and remove as needed. Any clothing brought in after admission must be labeled by laundry and added to the inventory list at the back of your resident's chart.

TELEPHONE

A public phone for resident use is available in the front lobby . If you wish to have a private phon, telephone installation, charge and monthly bills are the sole responsibility of the resident or responsible party. Telephone setup can be made with Windstream 1-800-347-1991.

VISITING HOURS

Visitors are welcome at anytime to this facility. We ask that family members use their best judgment and visit at responsible hours. We reserve the right to put restrictions on visitations according to the medical condition of the resident as well as specific orders from our medical staff.

AUTHORIZATION:

X Brenley Vaughn — 4/11/19

Responsible Party /Resident — Date

Facility Representative — Date

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CALHOUN CONVALESCENT CENTER

INFORMED CONSENT FOR RESTRAINTS

POTENTIAL BENEFITS:

1. Prevention of falls which might result in injury.
2. Protection from other accidents or injuries.
3. Allow medical treatment to proceed without patient interference.
4. Aid in maintenance of body alignment.
5. Protection of other patients or staff from disturbance or physical harm.
6. Increased patient feeling of safety and security.

POTENTIAL RISK:

1. Injury form falls.
2. Accidental death by strangulation.
3. Functional decline.
4. Skin abrasions, breakdown.
5. Biochemical, physiologic sequel of prolonged immobilization.
6. Cardiac distress.
7. Reduced appetite, dehydration.
8. Disorganized behavior.
9. Emotional desolation.
10. Possible increased mortality.

I have read and understand the above benefits and risks of restraints.

X Beverley Vaughn
Resident/Representative Signature Date

Beverley Vaughn
Printed Name of Resident/Representative

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CALHOUN CONVALESCENT CENTER

Effective October 1, 2008 we will no longer be accepting smoking residents in the efforts of becoming a smoke-free campus.

SMOKING POLICY

Smoking shall be prohibited in any room, ward or compartment where flammable liquids, combustible gases or oxygen is used or stored in any hazardous location, and such areas shall be posted with signs that read "No Smoking" or shall be posted with the international symbol for no smoking.

No one is permitted to smoke within the confines of the facility. Designated smoking areas are available for residents previously admitted. Previously admitted residents and staff will be oriented to the designated smoking area. Designated smoking areas are the covered porch and the courtyard porch.

Previously Admitted Residents: May smoke in designated smoking areas to include the covered front porch and court yard porch. Residents will be classified as responsible to smoke or not responsible to smoke. This classification will be based on a smoking assessment. The smoking assessment/determination will be reviewed quarterly and with any significant changes. Those classified as not responsible must have supervision to smoke.

Employees: May smoke in designated smoking areas, during breaks.
Visitors: May smoke in designated smoking areas.

**Effective October 1, 2008 we will no longer be accepting smoking residents in the efforts of becoming a smoke-free campus. **

Please understand that discharge may be warranted if you are caught smoking.

I, Beverley Vaughn have read, understand and agree to adhere to thi policy outlined above.

X Beverley Vaughn

Resident/Representative Signature Date

Beverley Vaughn

Printed Name of Resident/Representative

Authorized Agent of Facility Date

Printed Name & Title

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Photographs by State/Federal Survey Agencies

I acknowledge and understand that, during my/Resident's stay, Federal and/or State surveyors (investigators) may take my/Resident's photograph as part of their independent survey/investigation process and in line with conditions of my/Resident's participation in the Medicare and/or Medicaid program. I understand that, in line with CMS guidelines, the surveyors must obtain written consent from Resident or his/her surrogate before any photographs are taken. I understand that the Federal/State Survey Agency is wholly responsible for acquiring and securing any photographs they may take.

☒ BV. I acknowledge and understand that neither Facility nor its parent, affiliates, officers, directors, employees, attorneys, assigns or any other person acting on its behalf, has any oversight or responsibility for the surveyors actions or inactions as it relates to taking photographs for their independent investigations.

Photograph/Audiotape/Videotape ☐ Yes_____ ☐ No _____

I hereby authorize Facility to photograph/audiotape/videotape me/Resident for its use in resident identification, infection control, surveillance and/or other medical purposes. I understand that, if the facility wishes to photograph/audiotape/video tape me for any other reason, (activities, marketing, media coverage, etc.), the facility will secure permission from me through a separate written authorization.

Posted Information ☐ Yes_____ ☐ No _____

To better serve you and meet your health care needs, permission is needed to post information regarding your/Resident's health care needs within your room and the facility as needed. The information to be disclosed will be the minimum amount necessary and shall serve as a means of communication, enabling staff to provide service while, at the same time, ensuring your/Resident's rights to privacy. Information to be disclosed may include, but not be limited to, therapy schedules, activities of daily living, ambulation/mobility parameters, swallowing and aspiration precautions, do-not-resuscitate orders.

Authorization to Release and Obtain Information ☐ Yes_____ ☐ No_____

I hereby authorize the facility to release and/or obtain medical information or other necessary data which may be necessary for my/Resident's continued treatment and care at the facility, including but not limited to the filing of insurance claims in my/Resident's/Facility's interest. I further authorize the release of information, medical or otherwise, to any government agency without my prior approval or that of my representative, if any.

Authorization to Receive/Open Mail ☐ Yes_____ ☐ No _____

I hereby authorize Facility to open all mail received by me/Resident. Further, I would like this mail to be read to me/Resident upon receipt. You have the right to revoke this authorization at any time upon written notice to the facility.

***** SIGNATURE PAGE FOLLOWS*****

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Resident Signature Date

Printed Name of Resident

X Beverly Vaughn

Legal Representative Signature, if any Date

X 4/11/19

Printed Name of Representative

Witness Signature Date

Printed Name of Witness

Facility Representative Signature Date

Printed Name and Title

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I acknowledge I have received the following information and/or documentation, which fully explains my rights under Federal and applicable state laws as a nursing home resident, and the rules and regulations governing my conduct as a resident. *(Resident/Representative should check and initial each item listed as it is furnished and explained.)*

X _____ A written copy of Facility's Admission Agreement

X _____ A written copy of Facility's Handbook, which includes the facility's rules/regulations governing resident conduct, as well as written explanations of the following: (Admission, Discharge and Readmission policies; Bed assignment, reservation, and refund policies; Protection of Resident Funds; Resident's Rights under Federal law; Bed Hold policies; Polices/procedures for bringing personal items into the facility and securing personal belongings, valuables and money; Special Services, such as laundry, barbers and activities; Policies/procedures for filing grievances; Medicare/Medicaid Funding; Smoking Policies)

X _____ A written copy of resident's rights under applicable state laws.

X _____ A written copy of facility's policy on Advance Directives.

X _____ A written explanation of the charges for services provided by facility and outlined in the Handbook and those services offered on an as-needed basis.

X _____ A separate listing of local and government resources as furnished by the state Ombudsman and any other advocacy groups as required by state/federal law.

X _____ A separate listing of all medical professionals available to provide on-site services.

X _____ A written copy of facility's policy on the use of physical or chemical restraints, including bed rails.

X _____ A written copy of facility's Notice of Privacy Practices.

By my signature below, I agree to abide by all facility's rules, policies, terms and conditions as explained to me and provided above, as well as all federal and applicable state laws.

Resident Signature Date	Printed Name of Resident
X Beverley Vaughn 4/11/19	X Beverley Vaughn
Legal Representative Signature, if any Date	Printed Name of Representative
Witness Signature Date	Printed Name of Witness
Facility Representative Signature Date	Printed Name and Title

FFUS002(a) – Admission Handbook Acknowledgment

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ELECTRONICALLY FILED - 2024 Feb 06 10:05 AM - ORANGEBURG - COMMON PLEAS - CASE#2022CP3800525

D H E C
PROBITY PROTECT PROSPER

Emergency Medical Services
Do Not Resuscitate Order

SOUTH CAROLINA
EMERGENCY MEDICAL SERVICES

RESUSCITATE

DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to Mary McCully (Name of Patient) that he/she has a terminal condition which has been diagnosed by me and is at least eighteen (18) years of age, and has specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MUTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date 4/11/19

X Beverley Vaughn
Patient's Signature (or Surrogate or Agent)

Physician's Name (Please Print)

Physician's Signature

Physician's Address

Physician's Telephone Number

SPECIAL CARE

DENTAL / VISION / AUDIOLOGY / PODIATRY CONSENT

Patient Name Mary McCollys

CONSENT FOR TREATMENT

Provider by specialty:

- Dentistry: Special Care Dental
- Optometry: Special Care Vision
- Podiatry: Special Care Podiatry
- Audiology: Special Care Hearing

By signing below you authorize the provider indicated above to provide treatment on the above-named patient. For dentistry, your consent includes each of the following unless you have drawn a line through such procedure(s) below:

- Examinations
- Cleanings, debridement, scaling and root planing
- X-rays
- Fillings
- Dentures, including new and repairs, relines, or adjustments of existing

You acknowledge that no guarantees or assurances have been made concerning the results intended from the treatment and that any procedure carries a certain amount of risk. You also assign qualified payments from the patient's applicable insurance, including Medicare, to the provider and his/her agents.

REFUSAL OF CONSENT

Only if you do not consent to treatment for one or more of the above services, complete this section. As legal representative I opt to be financially responsible and provide the following care out of the facility (check the box for any service you do not consent to):

☐ Dentistry services ☐ Optometry services ☐ Podiatry services ☐ Audiology services

SIGNATURE

Sign Here X Beverly Vaughn

Signature of Patient/Person Authorized to Make Medical Decisions

4/11/19

Date

www.SpecialCareManagement.com
Fax: (502) 254-4074

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LAUNDRY

Loris Paris
Resident

Date

[redacted]
Medical Record Number

Room #

X
Family will do laundry

Facility needs to do laundry

If at any time you want to change, please inform the Social Services Director or the Receptionist.

Beverley Vaughn
Resident/Responsible Party

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RECEIVED
Nov 12 2025
SC Court of Appeals

CERTIFICATE OF COUNSEL

The undersigned counsel for Appellants certifies that, in accordance with Rule 210(c), SCACR, this **Supplemental Record on Appeal** contains all material proposed to be included by any party that was presented to the lower court and not any other material and complies with the Supreme Court of South Carolina's Revised Order Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings issued April 15, 2014.

Respectfully submitted,

CLEMENT RIVERS, LLP

By: s/Russell G. Hines

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Attorneys for Appellants

Charleston, South Carolina

November 12, 2025