THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

RECEIVED
JAN 23 2019
SC Court of Appeals

Case No. 2016-001732

Hilda Stott, individually and as Personal Representative of the Estate of Jolly P. Davis, deceased, and as Personal Representative of the Statutory Beneficiaries, ...Respondents,

v.

White Oak Manor, Inc.; White Oak Management, Inc.; and White Oak Manor-Spartanburg, Inc. d/b/a White Oak of Spartanburg..Appellants.

SUPPLEMENTAL RECORD ON APPEAL

THE WARD LAW FIRM, P.A.

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STATE OF SOUTH CAROLINA)
)
COUNTY OF SPARTANBURG)

IN THE COURT OF COMMON PLEAS
(Jury Trial Requested)

Hilda Stott, individually and as Personal Representative of the Estate of Jolly P. Davis, deceased, and as Personal Representative of the Statutory Beneficiaries,

Plaintiffs,

v.

White Oak Manor, Inc.; White Oak Management, Inc.; and White Oak Manor - Spartanburg, Inc. d/b/a White Oak of Spartanburg,

Defendants.

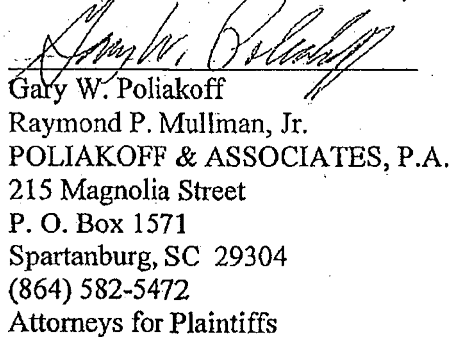
C.A. NO.: 2015-CP-42-5123

SUMMONS
(Wrongful Death and Survival Action)

2015 DEC 16 PM 1:1_
M. HOPE BLACKLEY

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is hereby served upon you, and to serve a copy of your Answer to said Complaint on the subscriber at their offices, 215 Magnolia Street, Post Office Box 1571, Spartanburg, South Carolina, 29306 (29304) within thirty (30) days after service thereof, exclusive of the date of such service; and if you fail to answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint.

RESPECTFULLY SUBMITTED,



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December 16, 2015.
Spartanburg, S.C.

STATE OF SOUTH CAROLINA)
)
COUNTY OF SPARTANBURG)

IN THE COURT OF COMMON PLEAS
(Jury Trial Requested)

Hilda Stott, individually and as Personal Representative of the Estate of Jolly P. Davis, deceased, and as Personal Representative of the Statutory Beneficiaries,

Plaintiffs,

v.

White Oak Manor, Inc.; White Oak Management, Inc.; and White Oak Manor - Spartanburg, Inc. d/b/a White Oak of Spartanburg,

Defendants.

C.A. NO.: 2015-CP-42-5123

COMPLAINT
(Wrongful Death and Survival Action)

2015 DEC 16 PM 1:15
M. HOPE BLACKLEY

The Plaintiff, Hilda Stott, as Personal Representative of the Estate of Jolly P. Davis, does hereby respectfully allege as follows:

PARTIES AND JURISDICTION

1. That the Plaintiff Hilda Stott, individually as Claimant #1, and as Personal Representative of the Estate of Jolly P. Davis (Claimant #2), is a citizen and resident of the state of Virginia.

2. That, upon information and belief, White Oak Manor, Inc. (hereinafter "WOManor") is a for-profit entity incorporated under the laws of the State of South Carolina and is licensed and doing business in the County of Spartanburg, State of South Carolina.

3. That, upon information and belief, White Oak Management, Inc. (hereinafter "WOManagement") is a for-profit entity incorporated under the laws of the State of South Carolina and is licensed and doing business in the County of Spartanburg, State of South Carolina.

4. That, upon information and belief, White Oak Manor-Spartanburg, Inc. d/b/a White Oak of Spartanburg (hereinafter "WOS") is a for-profit entity incorporated under the laws of the State of South Carolina and is licensed and doing business in the County of Spartanburg, State of South Carolina.

5. That, upon information and belief, WOManor and WOManagement own, operate, manage, and oversee WOS.

6. That, upon information and belief, at all times relevant hereto, WOS has operated a nursing home facility and has done business in the state of South Carolina.

7. That, upon information and belief, at all times relevant hereto, Jolly P. Davis (hereinafter "Plaintiff Davis") was a resident of WOS and there existed a resident/facility relationship between Plaintiff Davis and the Defendants, and therefore Plaintiff Davis was thereby entitled to all the protections afforded such residents in South Carolina.

8. That, Plaintiff Davis was a resident of WOS at all times relevant hereto in the County of Spartanburg, State of South Carolina, and was a vulnerable adult as defined by S.C. Omnibus Adult Protection Act.

9. That, upon information and belief, at all times relevant hereto, WOS delivered nursing home care for a fee and had authority, express or implied, to control the means and agencies employed to execute the delivery of nursing home care to Plaintiff Davis during his residency at WOS.

10. That, upon information and belief, at all times relevant hereto, WOManor and WOManagement directly participated in the ownership, operation, and/or management of nursing homes for profit, including the facility where Plaintiff Davis resided. Further, WOManor and WOManagement, at all times relevant hereto, exerted managerial control and operational control over WOS, and that such control was so extensive and pervasive that WOManor and WOManagement actually operated and managed said facility, and did business as said facility. Further, the control by WOManor and WOManagement was so extensive and pervasive over WOS that the business of WOS was the business of WOManor and WOManagement.

11. That, upon information and belief, at all times relevant hereto, all Defendants named herein are or have been involved in budget, staffing, training, supervision, development, management, consulting and implementation of policies and procedures for WOS and have directly controlled the operations at said nursing home facility.

12. That, upon information and belief, at all times relevant hereto, all Defendants have engaged in substantial business activities in South Carolina, including the management, operation, control and/or ownership of the Defendant nursing home facility during the relevant time period.

13. That, upon information and belief, at all times relevant hereto, all Defendants named herein have promulgated and established the policies, procedures, protocols, staffing decisions, and budgetary decisions at WOS, and all Defendants named herein have directly controlled said facility at various times.

14. That, upon information and belief, at all times relevant hereto, the acts and omissions causing Plaintiff Davis' injuries deficiencies at WOS nursing home facility in Spartanburg County, South Carolina were authorized, approved and ratified by all Defendants named herein.

15. That the Court has jurisdiction over all the parties and subject matter.

16. That the acts and delicts referred to herein occurred at Defendants' facility in the County of Spartanburg, State of South Carolina.

17. That this action is being brought pursuant to the South Carolina Common Law of Negligence, Gross Negligence, Negligence Per Se, Wrongful Death, Unjust Enrichment, Breach of Fiduciary Duty and the Unfair Trade Practice Act.

GENERAL FACTUAL ALLEGATIONS APPLICABLE TO ALL CLAIMS

18. That on January 2, 2013, Plaintiff Davis was admitted to WOS with the understanding that he would be provided with the care that his health conditions reasonably required.

19. That while residing at Defendants' facility, Plaintiff Davis was damaged and injured, and eventually died as a result of custodial neglect and negligence, including violations of the standard of care for nursing and custodial care.

20. That Plaintiff Davis was a resident of Defendants' facility from his admission until his discharge on January 6, 2013.

20. That, while a resident at Defendants' facility, Plaintiff Davis was overmedicated and dehydrated which led to his untimely death.

21. That Defendants' facility failed to properly monitor and care for Plaintiff Davis by failing to ensure he was hydrated and not given unnecessary medications.

22. That, at all times relevant hereto, Defendants were required to exercise due care in the supervision and care of their residents to prevent the occurrence of new adverse health conditions and to prevent currently existing adverse health conditions from deteriorating.

23. That during Plaintiff Davis's residency at WOS, the acts and delicts of Defendants caused, and were the proximate causes of Plaintiffs' conscious pain and suffering, mental distress, medical bills, funeral bills, loss of dignity, and wrongful death.

24. That the Plaintiff institutes this action in order to recover for Plaintiff's injuries. Said injuries and damages were the proximate result of the acts and delicts of Defendants.

25. That the provisions of the Omnibus Reconciliation Act of 1987 ("OBRA") were applicable with regard to Plaintiff Davis. Defendants were under an obligation to follow all rules and regulations of OBRA as well as all applicable state and federal laws, rules, regulations, and guidelines including S.C. Regulations 61-17, the South Carolina Adult Protection Act, and the South Carolina Nurse Practice Act, S.C. Code § 40-33-5 et. seq.

26. That the Defendants were liable and responsible for the acts and delicts of their employees, agents, and servants under the principle of respondeat superior.

27. That Defendants are vicariously liable for the acts and delicts of their employees, agents, and servants.

28. That the Defendants held WOS out to the State of South Carolina, the South Carolina Department of Health and Environmental Control, the public at large, and specifically to Plaintiff Davis and his family, as being:

a. skilled in the performance of nursing, rehabilitative, and other medical support services;
b. properly staffed, supervised and equipped to meet the total needs of its residents;
c. able to specifically meet the total nursing, personal care, medical, physical therapy, and
d. licensed by the South Carolina Department of Health Environmental Control and complying on a continual basis with all state and federal rules, regulations, and standards established for nursing homes in South Carolina.

29. That the Defendants held WOS out to the United States of America, the Centers for Medicare and Medicaid Services, the public at large, and specifically to Plaintiff Davis and his family, as being a skilled nursing facility and as a nursing facility meeting the requirements of 42 CFR Part 483.

30. That the Defendants were under a fiduciary duty to provide reasonable, appropriate and adequate care to Plaintiff Davis pursuant to state and federal laws, rules, regulations, guidelines and existing industry standards.

31. That the Defendants owed certain non-delegable duties to Plaintiff Davis including, but not limited to, the duties set forth in the foregoing and ensuing paragraphs of this complaint.

32. That, at all times pertinent hereto, Plaintiff Davis resided at Defendants' facility, and as such was under the exclusive control and care of Defendants and their employees, agents, officers, and servants while a resident.

33. That, at all times pertinent hereto, WOS, as licensee was ultimately responsible for maintaining approved standards for the facility.

34. That the Defendants, their officers, agents, servants, and employees negligently and carelessly failed to provide care and treatment to Plaintiff Davis.

35. That, upon information and belief, Plaintiff Davis's health conditions were aggravated and exacerbated by the Defendants' repeated failure to properly supervise him or monitor his medical conditions and keep him safe from harm in that he suffered from being overmedicated, from dehydration, neglect, and mental and emotional distresses, which ultimately led to his wrongful death. These deviations from the standard of care were the proximate causes of conscious pain and suffering, mental distress, medical bills, funeral bills, loss of dignity, and wrongful death.

36. That Defendant WOS, directly or indirectly, received federal and state funds as

reimbursement of the care of residents including Plaintiff Davis.

FIRST CAUSE OF ACTION
(Negligence, Recklessness, and Gross Negligence)

37. Relevant and consistent allegations contained in paragraphs 1-36 are incorporated by reference as if written verbatim herein.

38. That Defendants had a duty of due care to their patients and residents to discover, warn and/or prevent risks; to take reasonable safety precautions; to eliminate unreasonable risks; and to provide proper protection from harm.

39. That Defendants, named hereinabove, had a duty to treat the Plaintiff at a level that met or exceeded the recognized standard of care, which Defendants breached.

40. That Defendants, by and through Defendants' agents, servants, and employees were negligent, reckless, grossly negligent, willful, wanton, reckless and careless in treatment of the Plaintiff, and that Defendants performed duties in a manner well below the recognized standard of care for the same or similar provisions in the same or similar circumstances.

41. That Defendants had a duty of due care to their patients and residents to discover, warn and/or prevent risks; to take reasonable safety precautions; to eliminate physical, mental or emotional unreasonable risks; and to provide proper protection from harm.

42. That Defendants, by and through their agents, servants, and employees, were negligent, willful, wanton, reckless, careless and grossly negligent and deviated from the expected standards of skill, care, and learning in their treatment of Plaintiff Davis. More particularly the Defendants were negligent in the following particulars:

   a. failing to properly supervise as required, and as promised to the family upon admission;
   b. failing to provide the care, supervision and monitoring of patients, residents, and, in particular, Plaintiff Davis, which was required by law and which was necessary for his health and safety;
   c. failing to hire, train, and supervise personnel to properly avoid preventable injuries to residents and, in particular, Plaintiff Davis;
   d. failing to provide sufficient numbers of qualified personnel including nurses, nurses assistants, medication aides, and/or orderlies to meet the total needs of Plaintiff Davis;
   e. failing to abide by applicable federal and state laws governing long term care facilities and nursing care;
   f. failing to hire a sufficient number of trained and competent staff and failing to sufficiently budget for same;
   g. failing to follow the licensing and regulatory rules of the State of South Carolina;
   h. failing to develop and follow an appropriate Plan of Care;

i. failing to properly train employees to deal with residents who were unable to care for themselves;
j. failing to provide emergency services when needed;
k. failing to prevent Plaintiff Davis from becoming overmedicated;
l. failing to properly monitor Plaintiff Davis;
m. failing to appropriately diagnose Plaintiff Davis's condition;
n. failing to provide adequate hydration;
o. failing to provide an adequate plan of care to include necessary interventions to promote hydration and prevent dehydration;
p. failing to consult with and/or report to the physician and/or the Registered Dietician in a timely manner Plaintiff Davis's decrease in fluid intake and changes in condition;
q. failing to keep Plaintiff Davis properly hydrated and nourished;
r. failing to keep Plaintiff Davis' chart free of fraudulent documentation;
s. failing to monitor and assess Plaintiff Davis adequately for pain and discomfort;
t. failing to treat Plaintiff Davis with dignity and respect;
u. failing to exercise due care; and
v. by other negligent acts and/or omissions yet to be determined or defined.

43. That, as a result, Plaintiff Davis experienced conscious pain and suffering, mental anguish, and suffered wrongful death.

44. That the aforesaid acts and delicts were the sole and proximate cause of Plaintiff Davis's injuries and death.

45. That the wrongful conduct of Defendants set forth in the negligence, gross negligence, and negligence per se counts of this complaint was undertaken without regard to the health and safety consequences of Plaintiff Davis who was entrusted to Defendants' care, and rises to the level of gross negligence in that Defendants' conduct was willful, wanton, reckless, and shows a conscious disregard for the health and safety of Plaintiff Davis.

46. That the Defendants independently and through their managers, officers and others yet unknown demonstrated conscious and intentional disregard of and indifference to the rights and safety of Plaintiff Davis and other patients at WOS as demonstrated by:

    a. Their business practice of attempting to care for residents with an inadequate number of trained staff, which their officers and managers knew or should have known were reasonably likely to result in injury to Jolly P. Davis and their other patients; and

    b. Their business practice of failing to supervise and train their staff in order to ensure that their policies and procedures were known to and adhered to by licensed staff, and that licensed staff practiced within their scopes of practice.

SECOND CAUSE OF ACTION
(Negligence Per Se)

47. Relevant and consistent allegations contained in paragraphs 1-46 are incorporated by reference as if written verbatim herein.

48. That in addition to the above, Plaintiff alleges that Defendants have been negligent per se in their violations of sections of OBRA (Omnibus Budget Reconciliation Act of 1987), S.C. Regulations 61-17, the Adult Protection Act, and the Nurse Practice Act.

49. That each and/or all of the foregoing state and federal laws, rules and regulations prescribe certain actions or define the standard of conduct. Plaintiff Davis was and remains in the class of persons sought to be protected by each regulation and/or statute. Moreover, Plaintiff's injuries were the type of harm that each of these regulations were intended to prevent according to the extent that the Defendants' conduct violated these regulations. Such conduct amounts to negligence per se as that term is defined and is known and understood at law. Each act or omission constituting negligence per se was the proximate cause of Plaintiff Davis's injuries and damages.

50. That as a direct and proximate result of the Defendants' acts and delicts, Plaintiff Davis endured extreme conscious pain and suffering, mental distress, medical bills, funeral bills, loss of dignity, and wrongful death.

51. That reasonable custodial care requires that the facility provide each resident with sufficient fluid intakes to maintain proper hydration, per said regulations and statutes.

52. That dehydration is considered a sentinel event and life threatening.

53. That residents need at least one point five (1.5) liters of fluids daily to avoid dehydration and maintain health, which Defendants failed to provide, in further violation of said regulations and statutes.

THIRD CAUSE OF ACTION
(Unjust Enrichment)

54. Relevant and consistent allegations contained in paragraphs 1-53 are incorporated by reference as if written verbatim herein.

55. That Defendants received funds from both the state and federal government which were intended to be used to properly care for Plaintiff Davis.

56. That Defendants did not use said funds to properly care for Plaintiff Davis, and were therefore unjustly enriched by receipt of said funds.

57. That as a result of aforementioned misuse of funds, Plaintiff Davis suffered conscious pain and suffering, mental distress, medical bills, funeral bills, loss of dignity, and wrongful death.

FOURTH CAUSE OF ACTION

(Breach of Fiduciary Duty)

58. That relevant and consistent allegations contained in paragraphs 1-57 are incorporated by reference as if written verbatim herein.

59. That, according to the South Carolina Adult Protection Act, at all times relevant hereto Plaintiff Davis was considered a vulnerable adult.

60. That a fiduciary relationship existed between Defendants and Plaintiff Davis.

61. That Plaintiff Davis trusted in, confided in and relied upon Defendants to use their expertise and discretion for his care.

62. That Defendants accepted Plaintiff Davis's trust and reliance and so became responsible for Plaintiff Davis's health while residing at the nursing home facility.

63. That as a result of aforementioned reliance and trust upon Defendants, Plaintiff Davis's physical and mental health was placed in the hands of Defendants.

64. That Defendants breached this fiduciary relationship by allowing Plaintiff Davis's physical and mental health to deteriorate during his residency at the nursing home facility.

<u>FIFTH CAUSE OF ACTION</u>
(Joint Venture)

65. That relevant and consistent allegations contained in paragraphs 1-64 are incorporated by reference as if written verbatim herein.

66. That a joint venture is an association of two or more individuals engaged in a solitary business enterprise for profit without actual partnership or incorporation.

67. That elements of joint venture in the State of South Carolina are:

    a. an agreement;
    b. a joint interest in a common business;
    c. an understanding that profits and losses will be shared, and;
    d. a right to joint control.

68. That a joint venture exists when there is:

    a. contribution of resources by both parties;
    b. joint proprietorship and control over the subject matter of the property engage in the venture;
    c. sharing of profits by express or implied agreement, and;
    d. an express or implied contract showing join venture.

69. That all Defendants herein were involved in a joint venture.

SIXTH CAUSE OF ACTION
(Alter Ego)

70. Relevant and consistent allegations contained in paragraphs 1-88 are incorporated by reference as if written a verbatim herein.

71. That, upon information and belief, WOS was dominated by WOManor and WOManagement before, during, and after Plaintiff Davis's residency. These Defendants siphoned profits from the nursing home chain through self-dealing between the entities, excessively compensated themselves and other executives, and participated in other methods of divesting the licensee entities of needed capital and assets, while allowing the chain to suffer financial losses and provide poor care as a result of inadequate capitalization and consequently inadequate supplies and staffing, resulting in unnecessary injuries, death and suffering, including that of Plaintiff Davis.

SEVENTH CAUSE OF ACTION
(Wrongful Death)

72. Relevant and consistent allegations contained in paragraphs 1-71 are incorporated by reference as if written verbatim herein.

73. That as a direct and proximate result of Defendants' negligent, willful, wanton, reckless, careless and grossly negligent conduct, by and through their agents, servants, and employees, decedent was severely injured in Defendants' facility.

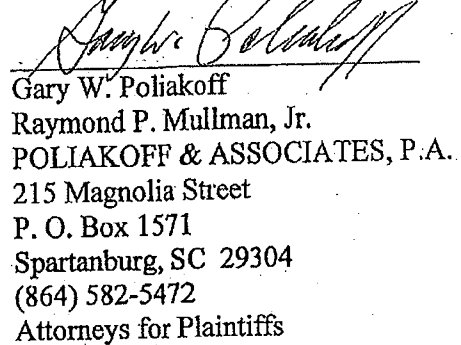
74. That the injuries so inflicted on the decedent were the proximate cause of Plaintiff Davis's wrongful death on January 16, 2013, resulting in the damages, injuries, harms and losses to the wrongful death beneficiary – Claimant #1 Hilda Stott.

75. That the sole and proximate cause of all the harms, losses, injuries and death suffered by Willie Wilson was the combined and concurrent acts and delicts of all the Defendants and their agents acting in a joint venture and integrated enterprise.

WHEREFORE, Plaintiff prays for judgment against the Defendants for actual and punitive damages in the sums deemed appropriate by the jury, for the costs of the action, and for such other and further relief as this Court may deem just and proper.

(SIGNATURE BLOCK BELOW)

RESPECTFULLY SUBMITTED,



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2015 DEC 16 PM 1:15
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COPY

Deviations from Standard of Care in Jolly Davis Case

1. Breach in the standard of care regarding medication orders and administration: Morphine is an opioid drug. According to the literature, "opioid is an effective palliative drug in chronic obstructive pulmonary disease patients with distressing dyspnea that is refractory to standard modalities of treatment." When it describes dyspnea that is refractory to standard treatments, it means that the usual treatments for COPD are not effective in alleviating symptoms. Standard treatments for COPD include, but may not be limited to the following, depending on the stage of COPD: smoking cessation, diet, minimizing risk factors (flu vaccine), cardiopulmonary rehab., supplemental oxygen, bronchodilators, and inhaled steroids. When these treatments fail to relieve the patient of dyspnea (breathlessness), the use of oral and parenteral opioids to palliate breathlessness is supported by a Cochrane review by Jennings et al.

   In the Cochrane review of 18 studies, types, doses and routes of administration of opioid were varied; clearly, the optimal opioid dosing for relief of dyspnea has not been established. *Palliative care experts' recommendation for treatment of severe dyspnea in opioid-naive patients is morphine sulfate 5 mg orally every 4 h; equivalent dose for break-through symptoms every 1–2 h as needed and to titrate in increments of 50–100% every 24 h. They further suggest to reduce the above-recommended doses by 50% and to titrate with increments of 25% every 24 h, as needed in severe pulmonary disease patients. Respiratory depression is a widely held concern for use of opioids in severe pulmonary disease patients. Eleven of the 18 studies included in the Cochrane review had information on blood gases or oxygen saturation. In all but one study, no significant changes were noted after opioid administration. The common gastrointestinal adverse effects of opioids are nausea, vomiting and constipation. However, except for constipation, these symptoms abate in 3 days to 2 weeks, as pharmacologic tolerance develops.*

   http://emedicine.medscape.com/article/297664-treatment#aw2aab6b6b3

http://www.medscape.com/viewarticle/717217_1

On **01/02/13**, an interim care-plan was filled out for Mr. Davis that included the following: monitor pain, non-drug interventions. There was no statement that he was actually experiencing any pain, and no location of any pain cited. In the White Oak physician orders, there was an order for Morphine ER (extended release) 15 mg PO Q 8 hours for a diagnosis of pain, though there was no documented evidence he was in any pain. This order was discontinued on 01/06/13, which is the day Mr. Davis was transferred to the hospital. On 01/06/13, the order was changed to Morphine 15 mg PO Q 12 hours "due to pain." This order was changed at the request of the niece, who was concerned that Mr. Davis was not alert enough to work with therapy.

According to the literature I have already cited, the recommended dose for severe dyspnea in opioid naïve patients (patients who are not chronically receiving higher doses of opioid analgesics on a daily basis) is 5 mg orally every 4 hours. This is equivalent to 30 mg/day. In addition, for patients with severe pulmonary disease, these recommended doses should be reduced by 50% due to the concern of respiratory depression.

It was a **deviation** for the nurses to follow an inappropriate order and not to question Dr. Warren over the inappropriate order. A nurse is a patient advocate, and when administering medication it is the standard of care to advocate for the patient by following the 5 R's of medication administration (some experts have added 3 more):

a. Right patient
b. Right medication
c. Right dose
d. Right route
e. Right time
f. Right documentation
g. Right reason (confirm the rationale for the ordered medication)
h. Right response

http://www.nursingcenter.com/Blog/post/2011/05/27/8-rights-of-medication-administration.aspx

Reference: Nursing 2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania.

In considering the right reason, Mr. Davis was ordered high doses of oral Morphine for the reason of pain, though he never complained of pain, nor is there evidence in the records that he had pain. A nurse note on 01/06/13 states he receives Morphine ER 15 mg every 8 hours for pain and Lortab 5 every 4 hours for breakthrough pain. Her note then states, "no complaints of pain or discomfort." When Hospice ordered Morphine for him in September of 2012, they ordered it for his dyspnea with any exertion. This was an appropriate reason.

There is an MAR note on 01/06/13 at 1:58 PM that states, Morphine ER 15 mg scheduled for 2:00 PM was refused by resident. He stated it makes him sleep and he wants to be alert for therapy tomorrow. This is an indication that Mr. Davis's Morphine dose needed to be reevaluated and adjusted.

It was also a **deviation** for the nurses not to question Dr. Warren's order to give Morphine ER every 8 hours. According to the instructions for administering ER Morphine, patients should *take morphine extended-release capsules on a regular schedule to get the most benefit from it. Do not take doses of morphine extended-release capsules closer than 12 hours apart.*

According to Mr. Davis' MAR, he was being given the Morphine ER every 8 hours: 6 AM, 2 PM, and 10 PM.

Another **deviation** was an order for Lortab 5-500 on the MAR, but no doctor's order for the Lortab. It is inappropriate to administer a drug without a physician order, especially a narcotic, which is a regulated drug. The order start date was 01/04/13, and the end date was 01/06/13. It is charted in the MAR that a dose of the Lortab at 02:39 AM on 01/05/13. Nurse stated her reason for giving the Lortab was "for general discomfort.

Resident says he just sore all over and doesn't feel good." There was no investigation of why he was sore and didn't feel good, and there was no clarification with the physician over whether Mr. Davis had a legitimate order for Lortab.

According to instructions for taking Dramamine, it is inappropriate to take/give it for nausea and vomiting not caused by motion sickness. It is an antihistamine, and it's use should be limited to motion sickness and only for nausea, vomiting, and dizziness associated with motion sickness. It can cause drowsiness. It is also not a drug of choice for patients with respiratory problems. The nurses should have been aware of these side effects, and should have questioned this order. There is also caution advised with giving Dramamine and Phenergan together because both can cause sedation. On 01/04/13 and 01/05/13, nurses administered 3 doses of Phenergan to Mr. Davis within 20 hours in addition to Dramamine 50 mg and 30 mg of Morphine ER. Giving this amount of drugs that have a sedative effect can increase, prolong, or intensify the sedative action of each drug, and so should be given with extreme caution, or not at all.

2. Breach in the standard of care for nurse documentation
    a. There is no documentation of ADL's. He initially had a catheter, so his urine outputs should have been checked each shift. There is no record of intakes and urine outputs. There is no record of his performance of any ADL's. There is no nurse or CNA documentation on the ADL sheets.
    b. There is not consistent documentation in the nurse notes of pain medication that was administered to Mr. Davis, nor any documentation of his response to pain medication (other than a dose of Lortab). According to a guide for documentation in nursing homes, the following should be documented when pain medication is being administered: date/time, location of pain, description of pain and score on pain scale 1-10, goal for resident's relief, whether or not pain limits ADL functions or interferes with sleep, whether resident's pain goal is met, and whether the medication is effective (how

resident responded).
https://www.gmcf.org/AlliantWeb/Files/QIOFiles/Nursing%20Homes/charting-guide.pdf

c. There are discrepancies in the chart about whether or not Mr. Davis had a fall on 01/03/13. At 04:10 AM on 01/03/13, Beth Painter, LPN charts that Mr. Davis had a fall earlier in the day. On 01/04/13, at 04:13 AM and at 04:14 AM, Cheryl Henderson, RN, states that the note regarding the fall written on 01/03/13 did not pertain to Mr. Davis. MDS assessment on 01/06/13 states Mr. Davis has had 1 fall since admission to SNF, and he suffered minor injury. Nurse note by Karen Sylvester, RN, on 01/15/13, at 07:33 AM stated he had nausea and a fall on 01/03/13.
https://www.gmcf.org/AlliantWeb/Files/QIOFiles/Nursing%20Homes/charting-guide.pdf

"Documentation is a matter of good clinical practice and is an expectation of trained and licensed health care professionals."

3. Failure to follow-up on lab results and to report abnormal lab results: abnormal labs drawn on 01/04/13, and resulted on either 01/04/13 or 01/05/13 were PT-23.9 (nl.-10.5-13.5), INR-2.03, Glucose-59 (nl.-70-105), BUN-60 (nl.-7-25), Iron-31 (nl.-50-212), vitamin B12-1315 (nl.-211-911)-can be elevated in patients with diabetes, WBC's-23.3 (nl.-4-11), hemoglobin-11 (nl.-13.5-17.5). The rest of the labs drawn today were WNL. By the time the facility physician noted these labs on 01/07/13, Mr. Davis was already in the hospital. The nurses should have known there was an order for these labs to be drawn, and they should have noted when the report was received, and reviewed the lab results, and reported the abnormal ones to the doctor right away. Nurses are expected to be aware of abnormal lab results and to take appropriate action by informing the physician. An elevated BUN is indicative of kidney failure, and elevated WBC's are indicative of an infection. A nurse should be aware of this. In addition, Mr. Davis was receiving B12 supplementation, and when his level was elevated, the nurse should have informed the physician so his supplement dose could

have either been lowered or discontinued. Textbook of Basic Nursing. Edited by Caroline Bunker Rosdahl, Mary T. Kowalski

4. Failure to report change in condition and to monitor Mr. Davis closely: beginning on 01/04/13, Mr. Davis began complaining of nausea and vomiting. He also complained of watery stools. This led to his refusal to take his medications and to take in appropriate amounts of fluids. He also refused most of his meals for approximately 3 days. This was not reported to the physician. A nutrition consult was not ordered. There was no monitoring of intake and output. This combination of vomiting, diarrhea, and lack of oral intake can cause serious dehydration, and this was confirmed on his admission to SRMC on 01/06/13.

Sarah Kaminski, RN
April 30, 2015

Rosemary E Wilcox 4/30/15
Comm expires Jan 10, 2024

COPY

SPARTANBURG
Regional Healthcare System

☑ SRMC ☐ SHRC ☐ VH

PROGRESS NOTE ADDRESSING DECISIONAL CAPACITY

Based upon my observation and involvement with this patient, it is my medical opinion that

Jolly Davis (Name of Patient) Account Number: 1235601402

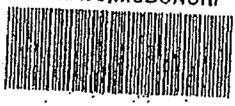
Check ONE of the following statements

Attending Physician	Second Physician
☑ This patient DOES possess the decisional capacity to make healthcare decisions for self.	☐ This patient DOES possess the decisional capacity to make healthcare decisions for self.
☐ This patient DOES NOT meet ALL of the criteria for decisional capacity, therefore is not able to make healthcare decisions for self. Furthermore, it is my opinion that due to the patient's medical condition(s), this lack of capacity is not likely to change in the immediate future.	☐ This patient DOES NOT meet ALL of the criteria for decisional capacity, therefore is not able to make healthcare decisions for self. Furthermore, it is my opinion that due to the patient's medical condition(s), this lack of capacity is not likely to change in the immediate future.
Criteria not met: _____ Oriented to ☐ person ☐ place ☐ time _____ Understands the nature of his/her illness _____ Ability to understand that decisions need to be made _____ Ability to communicate a decision _____ Ability to understand and use information logically to reach a decision _____ Ability to be realistic in decision making (i.e. to understand the consequences of a decision)	Criteria not met: _____ Oriented to ☐ person ☐ place ☐ time _____ Understands the nature of his/her illness _____ Ability to understand that decisions need to be made _____ Ability to communicate a decision _____ Ability to understand and use information logically to reach a decision _____ Ability to be realistic in decision making (i.e. to understand the consequences of a decision)
Progress Note	Progress Note
[signature] 1.2.13 (Attending Physician) (Date)	(Second Physician Involved in Care) (Date)

NOTE: A Psychiatric consult is NOT required. This form requires the signature of TWO PHYSICIANS. A Progress or Consult Note should be written regarding both the patient's medical condition and mental capacity. The completed form will be forwarded at discharge to the extended care facility.

Patient Label

1235601402 000-361128 12/22/12
DAVIS,JOLLY PERRY 07/14/37 M 75Y
ADM: RAJU,MUDUNURI
REF: RAJU,MUDUNURI STF ALT



1691 (Rev. 10-08)

RESIDENT AND FACILITY

ADMISSION AGREEMENT

WOM 000074

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RESIDENT AND FACILITY ADMISSION AGREEMENT
PLEASE READ CAREFULLY AND ASK ANY QUESTIONS

This Agreement is made by and between WOM-SPBG (hereinafter called "Facility") and Resident and his/her Authorized Representative and/or the individual who has access to Resident's income and financial resources available to pay for nursing care (hereinafter called "Authorized Representative") for the provision of nursing services for Jolly R. Davis (hereinafter called "Resident").

Resident and/or Authorized Representative affirm that the information provided during the admission process is true and correct to the best of their knowledge, and acknowledge that the submission of any false information may constitute grounds to terminate this Agreement.

Identification of Authorized Representative (if applicable):

The Authorized Representative is anyone authorized by the Resident or by law to act on the Resident's behalf. Please check the type and scope of authority for anyone other than the Resident who signs this Agreement.

TYPE (Check one)
- ☐ General POA*
- ☐ Durable POA*
- ☐ Durable POA w/ Healthcare*
- ☐ Guardianship / Conservatorship*
- ☐ Healthcare POA*
- ☐ Other:________________

SCOPE (check all that apply)
- ☐ Routine health care
- ☐ Unlimited health care
- ☐ Limited access to income / finance
- ☐ Authorized to accept income and control financial resources of Resident

*** Must provide copies of any and/or all documents checked above**

The Authorized Representative, by signing this Agreement, acknowledges acceptance of the duties and responsibilities of this role.

The Authorized Representative will not incur personal financial liability except for breach of duty or contract related to the misuse of Resident's resources or the failure to use those resources to pay for the Resident's care.

PRELIMINARY STATEMENTS:

Resident individually or by and through Resident's Authorized Representative has considered appropriate care settings and is desirous of receiving care at the Facility.

Facility is a licensed nursing facility and will provide the services set forth below in accordance with the applicable standards of care, none of which cause the Facility to become an insurer nor guarantor of the health and safety of the Resident; or for that matter, the insurer or guarantor of the Resident's personal property.

NOW, THEREFORE, in consideration of the prompt payment by the Resident (and the applicable state, federal, or private insurance program) of the charges made to the Resident's account in accordance with the charge structure of the Facility, and in further consideration of the mutual covenants and promises herein, the parties agree as follows:

2. PROVISION OF SERVICES

2.1. Care and Services. The Facility offers, at the Daily Rate, the following services: room accommodations, food services, licensed routine nursing services, social services, activities, housekeeping services, laundering of linens and towels, routine hair care, and resident trust fund services.

2.2. Ancillary Services and Supplies. The Facility shall make available at an additional charge, unless included in the Daily Rate, the following items and services: therapy services, medical supplies, laboratory services, pharmaceuticals, beauty/barbershop, guest meals, and toiletries for personal comfort, grooming, or hygiene, and transportation. All items and services not included in the Daily Rate, such as Medicare A or Medicaid, will be billed to the applicable payor. The Resident is responsible for all non-covered items and services, co-payments or deductible amounts, according to the Facility's Rate Schedule, as amended from time-to-time. Items and services not included in the Daily Rate will be updated periodically upon notice to residents.

2.3. Services of Other Providers. The services of outside providers such as a licensed physician, optometrist, podiatrist and/or dentist, a registered pharmacist for the provision of medications, rehabilitation therapies and diagnostic services, i.e., laboratory, x-ray and/or ambulance services, are available at the Facility or under arrangement. These services are available under guidelines and procedures established by the Facility and may be utilized by Resident at his or her own expense unless covered by another pay source. The Facility retains the right to control the source of supply of any items and contract services used within the Facility. Resident or Authorized Representative has exercised freedom of choice by applying for admission to Facility and thereby agrees and contracts with Facility to provide said supply items and contract services as requested. The place of purchase for pharmaceutical items is within Resident's freedom of choice subject to the Facility's policy for Resident drugs.

2.4. Role of Attending Physician and Medical Director. The Resident shall obtain the services of a qualified physician who will provide medical care during the Resident's stay at the Facility. The Resident is free to receive care from any licensed physician who agrees to submit credentials to the Facility and adhere to the Facility's policies and procedures. The Resident elects [handwritten] as the attending physician(s). [handwritten] (initials). The Facility is not obligated to provide Resident with any medicines, treatments, special diets or equipment without specific orders or directions from Resident's attending physician. In the event Resident's attending physician is unavailable, the Facility's Medical Director / Designee may issue appropriate orders. Resident is responsible to pay for all services or equipment ordered by Resident's attending physician or the Facility's Medical Director / Designee for Resident's care unless covered by Medicare / Medicaid or other third-party insurer.

2.5. Room Assignments. The Facility makes room and bed assignments according to availability and/or in accordance with the Resident's physical and psychosocial wellbeing. Resident acknowledges that bed assignments may be changed in order to provide a proper environment for all residents. Resident and family / Authorized Representative will be notified of any room changes.

3. CHARGES

3.1. Recurring / Periodic Charges for Care and Services. Resident shall pay the Daily Rate, specified in the Rate Schedule in effect at the time the service is rendered, for routine nursing services provided to Resident. The Daily Rate may be changed from time-to-time in accordance with the provisions of Section 4.3. Charges for a resident whose payor source is other than Medicare Part A or Medicaid will begin on the designated admission date or actual admission, whichever is earlier; charges for a resident whose payor source is Medicare Part A or Medicaid will begin no earlier than the date of admission.

3.2. Additional Charges for Ancillary Services and Supplies. Resident shall pay for other services and supplies provided by or through the Facility which are not covered by the Daily Rate as set forth in the Rate Schedule in effect at the time such ancillary services or supplies are rendered. Any items ordered by a physician, which are not identified on the Rate Schedule, will be provided at charges identified by the Facility. The charges for ancillary services and supplies are subject to change from time-to-time.

3.3. Charges for Outside and Non-Facility Services. In addition to the Facility's charges, Resident shall pay all fees and costs for goods or services furnished to or for Resident by anyone other than the Facility as described in Section 2.3 (Services of Other Providers) unless otherwise covered in full by Medicare or Medicaid or another third-party payor. Resident or Authorized Representative is obligated to pay such fees and costs whether the goods and services are furnished by a person or provider made available by the Facility, or by a person or provider selected by Resident, and whether the goods or services are provided at the Facility or elsewhere. These fees and costs are not included in the Daily Rate. Fees for professional services rendered by a physician are not included in the Daily Rate and will be charged directly to the Resident by the physician.

4. PERIODIC BILLINGS AND PAYMENT DUE DATE

4.1. Monthly Statements and Other Billings. Prepayment for one (1) month of the basic monthly rate is required at the time of admission. The Facility will mail Resident or Authorized Representative on or about the tenth (10th) day of the month a billing statement reflecting charges for care and services for the upcoming month and charges for ancillary services and supplies which were incurred in the prior month. Statements are due and payable upon receipt of the Monthly Statement.

Resident expecting Medicare coverage specifically understands that Medicare co-insurance is the responsibility of the Resident. Payment of co-insurance is required. Payment for Medicare services is not expected until services are rendered.

4.2. Failure to Pay and Cost of Collection. Failure to pay an account at the Facility when due is a breach of this Agreement and will allow Facility to discharge Resident upon giving a thirty (30) day written notice, during which thirty (30) day period the breach may be cured by payment of the account in full.

In the event the Facility initiates legal action to collect payments due from the Resident under this Agreement, and the Facility is successful, the Resident and/or Authorized Representative shall be responsible for reimbursing the Facility for all costs and expenses thereby incurred, including reasonable attorneys' fees.

4.3. Modification of Charges. The Facility reserves the right to change the Rate Schedule reflecting the amount of any of its charges or how and when charges are computed, billed or become due. The Facility shall provide thirty (30) days advance written notice of any such changes.

4.4. Obligations of Resident's Estate and Assignment of Property. Resident and Authorized Representative acknowledge the charges for services provided under this Agreement remain owed until paid. In the event of Resident's discharge for any reason, including death, this Agreement shall operate as an assignment, transfer and conveyance to the Facility of so much of Resident's property as is equal in value to the amount of any unpaid obligations under this Agreement. This assignment shall be an obligation of Resident's estate and may be enforced against the Resident's estate.

4.5. Change in Contact Information. Resident and/or Authorized Representative agree to notify the Facility within ten (10) days of any change in Authorized Representative's contact information.

5. MEDICARE / MEDICAID PROGRAMS

5.1. Participation in Programs. The Facility currently participates in the South Carolina / North Carolina Medicaid program and the federal Medicare program. The Facility reserves the right to withdraw from the Medicaid or Medicare programs at any time in accordance with law.

5.2. Actions of Medicaid and Medicare Agencies. The South Carolina / North Carolina Department of Health and Human Services ("DHHS") is responsible for administering benefits under the Medicaid program. The Centers for Medicare and Medicaid Services ("CMS"), of the United States Department of Health and Human Services, is responsible for administering the Medicare program through an intermediary. Resident acknowledges that the Facility is not responsible for, and has made no representations regarding, the actions or decisions of DHHS, CMS or the Medicare intermediary in administering the programs.

5.3. Medicaid Benefits.

5.3.1. Obligations of Resident. Resident is obligated to make full and complete disclosure regarding all financial resources and income during the application process. Failure to identify all resources and income, or the submission of false information, may result in the termination of this Agreement. Resident is obligated to notify the Facility when Resident's resources available to satisfy the Resident's financial obligations under this Agreement are no longer sufficient to pay all the Facility charges for Resident's care and services or when directed to do so by the Facility. Resident shall provide any documentation requested by the County Medicaid Office. Upon Facility's request, Resident shall execute an authorization for Facility to assist the Resident in securing Medicaid benefits, pursuing a hardship waiver, and bringing Resident's account current. In the event Resident applies for Medicaid benefits, Resident shall continue to pay and apply all of Resident's available resources toward the fulfillment of Resident's financial obligations under this Agreement while the Medicaid application is pending an eligibility determination by DHHS.

5.3.2. Recurring Liability Amount. For residents approved for Medicaid benefits, the Facility will accept payment from the State of South Carolina / North Carolina and, if applicable, the Resident's Recurring Liability Amount as determined by DHHS as payment in full only for those services covered by the Medicaid program. Resident remains obligated to pay such Recurring Liability Amount on a monthly basis. Services not covered by Medicaid are identified in the Rate Schedule and Resident remains obligated to pay for such services. If Resident plans to apply for Medicaid, then the Resident will have an estimated monthly Recurring Liability in the amount of $ N/A until the State determines the amount of Resident's income to be paid to the Facility. Once the approved Recurring Liability amount has been set by Medicaid, any differences must be paid or adjusted. The Recurring Liability amount is due to the Facility by the fifth (5th) day of the month. HS (initials)

5.3.3. Determination of Eligibility. Resident and Authorized Representative are obligated to cooperate fully in any Medicaid eligibility determination or re-determination process. In the event that Resident's eligibility for Medicaid benefits is denied, interrupted or terminated due to the failure of Resident or Authorized Representative to cooperate in the Medicaid application, re-determination or appeal process, the Resident and Authorized Representative shall be liable for the Daily Rate plus charges for ancillary services and supplies during any period of ineligibility, and the Facility may terminate this Agreement.

5.3.4. Authorization to Apply for and/or Appeal (Medicaid). In the event of Resident's incapacity and in situations where Resident's resources are depleted or appear to be depleted to the extent that Resident can no longer pay privately for nursing care, and it appears that Resident has become or will become eligible for Medicaid benefits to cover the cost of Resident's continued stay in the Facility; and if there is no other legal representative of Resident known to the Facility or other friend or relative known to the Facility who is authorized and/or is available or willing to act on Resident's behalf, after the Facility has made a good faith effort to identify such persons; then Resident hereby authorizes the Facility to request, file and/or apply for Medicaid benefits on behalf of Resident for the limited purpose of assisting Resident to secure payment through the Medicaid program for Resident's continued stay in the Facility. In the event the application for Medicaid benefits filed on behalf of the Resident is denied, or in the event Medicaid benefits are granted and subsequently discontinued, Resident hereby authorizes the Facility to file on Resident's behalf an appeal of any such denial of Medicaid eligibility or discontinuance of Medicaid benefits, and to take such actions to secure Resident's Medicaid benefits as the Facility deems reasonably necessary or appropriate and consistent with law. Resident warrants and represents that the financial information disclosed in the admission process is true and accurate and may be relied on by the Facility in pursuing Medicaid benefits on behalf of Resident.

5.3.5. Authorization to File a Hardship Waiver with DHHS on Behalf of Resident. If DHHS' application of a transfer of assets penalty operates to deprive Resident of medical care such that Resident's life would be in danger, or would deprive Resident of food, clothing or shelter, or the necessities of life, then in the event of Resident's incapacity, inability or unwillingness to act, and if there is no other Authorized Representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to file a Hardship Waiver with DHHS on Resident's behalf.

5.4. Medicare Part A and Part B Benefits. To the extent that Resident is a beneficiary under either Medicare Part A or Medicare Part B insurance and the nursing services or ancillary services or supplies ordered by a physician are covered by such insurance, the Facility or other provider will bill the charges for the covered services or supplies to the Medicare program. The Resident is responsible for and shall pay any co-insurance or deductible amounts under Medicare Part A or Part B insurance. The Facility shall accept payment from the Medicare intermediary as payment in full only for those services deemed to be covered in full under the Medicare Part A or the Medicare Part B program. Services not covered by Medicare are identified in the Rate Schedule.

5.5. Medicare Part B Payment Limitations: Therapy Caps.

5.5.1. General. Effective January 1, 2006, CMS imposed payment limitations on covered therapy services provided to individuals who are eligible beneficiaries under Medicare Part B. Under this financial limitation, Medicare will pay an annual capped amount for physical and speech therapy (combined) and an annual capped amount for occupational therapy. The capped amounts are revised by CMS

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annually. Facility shall provide Resident and/or Authorized Representative with notice of the current capped amounts as appropriate.

5.5.2. Resident's Responsibility to Pay for Therapy Services Beyond the Capped Amounts. Resident is responsible to pay the charges for all medically necessary therapy services in excess of the annual capped amounts, unless such therapy services are covered in whole or in part by private insurance or another government reimbursement program. In the event that another government reimbursement program or available third-party payor or insurance program denies coverage for therapy services provided to Resident after exhaustion of the annual capped amount, then Resident or Authorized Representative shall remain responsible to pay all fees and costs for all such therapy services. If Resident is not eligible for Medicaid, then failure to pay for therapy services rendered above the capped amount shall be grounds for termination and discharge from Facility pursuant to Section 10 of this Agreement.

5.5.3. Exception Requests.

5.5.3.1. Automatic Exceptions. Medicare beneficiaries may be automatically exempted from the annual therapy caps for certain conditions or complexities that have a direct and significant impact on the need for the course of therapy being provided and the additional treatment is medically necessary.

5.5.3.2. Manual Exceptions. Medicare beneficiaries not automatically exempted from the annual therapy caps are entitled to request an exception to the annual therapy caps, for up to fifteen (15) additional treatment days. In the event that Resident has exhausted the annual capped amount, and is not automatically exempted from the therapy caps, then the following shall apply:

5.5.3.2.1. Resident and/or Authorized Representative may submit an exception request to the applicable CMS Medicare contractor; or

5.5.3.2.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to submit an appropriate exception request to the applicable CMS Medicare contractor.

5.5.3.2.3. If the exception request is granted, then therapy services provided to Resident shall be covered by Medicare for the number of additional treatments approved. Once the additional approved treatments have been exhausted, Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.5.3.2.4. If the exception request is denied, then Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.6. Medicare Part D Prescription Drug Benefits.

5.6.1. Enrollment in Medicare Part D Plan. If Resident is an eligible beneficiary under the Medicare Part D insurance program and has enrolled or has been mandatorily enrolled in a Medicare Part D Prescription Drug or Medicare Advantage Plan ("PDP"), Resident shall advise Facility in writing of Resident's chosen PDP upon admission. In the event that Resident becomes an eligible beneficiary under Medicare Part D after admission or subsequently chooses to enroll in a PDP following admission, **Resident shall notify Facility in writing of Resident's chosen PDP prior to enrollment in the PDP. Resident shall advise Facility if Resident elects to change PDPs, and shall provide written notice of such election, including the name/identity of the newly selected PDP prior to the effective date of the change in the PDP.** ____ (Initial)

5.6.2. Resident's Responsibility to Pay for Pharmaceuticals. Resident is responsible to pay the charges for all prescription and other drugs or medications while a resident in Facility, except to the extent that such drugs and medications are covered in whole or in part by an applicable government reimbursement program. Some or all of the charges for prescription drugs and other drugs and medications may be covered by certain benefits available through Medicare Part D or other private insurance or governmental insurance / benefit programs, including Medicare Part A or B. In the event that coverage for any prescription drug, supply, medication or pharmaceutical provided to Resident is denied by any applicable governmental reimbursement program or other potentially available third-party payor or insurance program, then Resident or Authorized Representative shall remain responsible to pay for all such prescription drugs, supplies, other medications or pharmaceuticals.

5.6.3. Actions of Medicare Part D Plan. Facility is not responsible for and has made no representations regarding the actions or decisions of any PDP, including, but not limited to, decisions relating to the establishment of the PDP formulary, denial of coverage issues, or contractual arrangements between the PDP and the Resident, and with respect to any decisions made by the PDP relating to any long term care pharmacy provider that may be under contract with Facility.

5.6.4. Dually Eligible Residents. If Resident becomes eligible for Medicaid at any time during Resident's stay at Facility, and also qualifies for benefits under the Medicare Program, then Resident shall be required to enroll in a PDP (unless covered by private insurance) to ensure coverage of Resident's prescription drug needs. Resident and/or Authorized Representative shall take all necessary action to enroll Resident in a PDP, and shall advise Facility of such enrollment upon Resident's acceptance into the PDP. Resident acknowledges that should Resident fail to select a PDP, then CMS will assign Resident to a PDP. Resident shall provide written notice to Facility of the name of the Resident's PDP and the effective date of enrollment.

5.6.5. Billing and Resident Cost Sharing Obligations. To the extent that Resident is a beneficiary under Medicare Part D, and the pharmacy prescriptions and/or services ordered by a physician are covered by Medicare Part D, then the Pharmaceutical Provider (as required by law) shall bill the charges for the covered services to the Resident's PDP. Resident is responsible for and shall pay any and all cost-sharing amounts applicable under Medicare Part D insurance. Facility shall not be responsible to pay for any fees or cost-sharing amounts, including co-insurance and deductibles, relating to the provision of covered Medicare Part D pharmaceuticals to Resident. To the extent that Resident may qualify as a "subsidy eligible individual" who would be entitled to a reduction or elimination of some or all the cost-sharing or premium amounts under the Medicare Part D benefit, Resident and/or Authorized Representative has the sole responsibility to apply for such benefits.

5.6.6. Authorization to Request and/or Appeal Coverage Determinations. In the event that Resident is denied coverage under Resident's PDP for pharmaceutical services or supplies prescribed by Resident's attending physician, then the following shall apply:

5.6.6.1. Resident and/or Authorized Representative may independently (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determination.

5.6.6.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, or if Resident's physician is unable or unwilling to act on behalf of Resident, then Resident authorized Facility to (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determinations.

5.6.6.3. In the event of an initial denial of coverage by the Resident's PDP, then pending the outcome of an exception request, a request for re-determination, or an appeal, and in the event that Resident's attending physician fails to prescribe a clinically and reasonably acceptable substitute prescription medication, resident authorizes Facility Medical Director / Designee to prescribe a clinically and reasonably acceptable substitute prescription medication which is covered by Resident's PDP, if such clinically and reasonably acceptable substitute is available.

5.6.6.4. If a request for exception (filed by Resident, Facility or any other authorized representative) is ultimately denied following either reconsideration by the PDP or appeal to an appropriate tribunal, and if the requested pharmaceuticals are deemed medically necessary by Resident's physician, and

no reasonably acceptable substitute, as determined by Facility's Medical Director / Designee, from the formulary of Resident's PDP exists, then Facility shall make arrangements to provide the requested pharmaceuticals to Resident. In any such situation, Resident shall be responsible to pay all fees and costs for the non-covered pharmaceuticals, consistent with the requirements of this Section.

5.6.6.5. No Effect on Medicare Part A Covered Nursing Services. Resident's Medicare Part D prescription drug benefits do not apply while the Resident's stay in Facility is covered under Medicare Part A. While Resident is in Facility on a Medicare Part A stay, Resident's pharmaceutical needs generally are covered by the Medicare Part A program.

5.7. Non-Covered Services. Resident is and remains obligated to pay the Facility for services and supplies not covered by the Medicaid or the Medicare programs.

6. MANAGED CARE ORGANIZATIONS.

6.1. Participation in Managed Care Organizations. The Facility is an authorized provider of skilled nursing services to members of certain managed care organizations (MCOs). The MCOs for whom the Facility is an authorized provider are listed on Attachment "B".

6.2. Enrollment in a Managed Care Organization. Resident or Authorized Representative shall notify the Facility in writing prior to enrolling with an MCO or switching Resident's MCO enrollment.

6.3. Actions of Managed Care Organization. Resident acknowledges that an MCO for whom the Facility is not an authorized provider may not approve payment for services provided by the Facility. Resident acknowledges that the Facility is not responsible for and has made no representations regarding the actions or decisions of any MCO for whom the Facility is an authorized provider, including decisions relating to a denial of coverage.

6.4. Obligations of Resident. The Facility will accept payment from the MCO as payment in full only for those services and supplies covered by the MCO. Resident is responsible for any co-payments or other costs assigned to Resident under the specific terms of the managed care plan. Resident also shall pay for any services or supplies not covered by the MCO under the specific terms of the managed care plan. Co-payments and other costs assigned to Resident and charges for services or supplies not covered by the specific terms of the managed care plan are identified in the Rate Schedule. Managed care plans typically require pre-authorization of services by the MCO. If Resident chooses to have services which the MCO refuses to pre-authorize, Resident shall pay the Facility for those services. Resident shall pay the Facility in a timely manner for all non-covered services retroactive to the date of the initial delivery of services.

6.5. Withdrawal from Participation in the MCO. The Facility reserves the right to terminate its contractual relationship and its status as a network or authorized provider with one or more of the listed MCOs at any time in accordance with law and the terms of the applicable agreement. In the event that the Facility terminates its contractual relationship with the MCO in which Resident is enrolled, Resident may convert his or her coverage to a health plan for which the Facility is an authorized provider or transfer to a facility that is an authorized provider for Resident's MCO. The Facility shall provide thirty (30) days advance notice of its decision to withdraw as a participating provider from Resident's MCO so Resident and the MCO can coordinate a transfer to another facility.

6.6. Notice of Change in Insurance Coverage. Resident and/or Authorized Representative shall notify the Facility immediately of any change in Resident's insurance status or coverage made by the insurance carrier including, but not limited to, being dropped by the insurance carrier for any reason, or a decrease or increase in insurance benefits. Resident and/or Authorized Representative shall give the Facility notice before Resident is unable to meet Resident's insurance premium or before Resident implements an increase, decrease or termination from insurance coverage.

7. DURABLE FINANCIAL POWER-OF-ATTORNEY.

Resident shall submit, as appropriate, to Facility, no later than the date of admission, a durable Power-of-Attorney executed by Resident as Principal designating someone other than the Facility or a representative or affiliate of Facility as Agent, for the limited purpose of financial decisions and payment of services. In the event Resident fails to designate an Agent under a Power-of-Attorney, Resident shall be responsible to pay for any guardianship proceedings related to the appointment of someone or a legal entity to make decisions on behalf of Resident, if and when Resident lacks capacity to make such decisions as determined by Facility.

8. THIRD-PARTY PAYMENTS.

8.1. Eligibility for Third-Party Payments. Resident may be or may become eligible to receive financial assistance, reimbursement, or other benefits from third parties, such as private insurance, employee benefit plans, Medicaid under the South Carolina / North Carolina Medicaid Program, Medicare benefits, managed care coverage, supplementary medical or other health insurance, supplemental security income insurance, or old-age survivors' or disability insurance. It is the responsibility of the Resident and/or Authorized Representative to apply for these benefits. If Resident is or becomes eligible to receive payments from any third parties for Resident's stay and care, the Facility reserves the right to collect such payments directly from the third-party source. The Resident and Authorized Representative shall at all times cooperate fully with the Facility and each third-party payor to secure payment. Cooperation includes providing information; signing and delivering documents; and assigning to the Facility (to the extent permitted by law) any payments for the Resident from federal or state governmental assistance programs or any other reimbursements or benefits to the extent of all amounts due the Facility.

8.2. Assignment of Payments. Resident irrevocably authorizes the Facility to make claims and to take other actions to secure for the Facility receipt of third-party payments to reimburse the Facility for its charges for the stay and care of Resident. To the fullest extent permitted by law, as security for payment of the Facility's charges, Resident hereby assigns to the Facility all of Resident's rights to any third-party payments now or subsequently payable to the extent of all charges due under this Agreement. Resident or Authorized Representative promptly shall endorse and turn over to the Facility any payments received from third parties to the extent necessary to satisfy the charges under this Agreement. Resident or Authorized Representative shall sign any necessary documents to forward third-party payments directly from the payor to the Facility.

8.3. Insurance. The Facility will bill Medicare and Medicaid for any services rendered to Resident by the Facility. The Facility may, at its discretion, bill Resident's private / supplemental insurance carrier for services rendered to Resident by the Facility. In the event of an initial or subsequent denial of coverage by the Resident's insurance carrier, Resident shall pay the Facility timely for all non-covered services retroactive to the date of the initial delivery of services, so long as such payment obligation is consistent with the regulations governing the Facility's participation in the Medicare and Medicaid Programs. [illegible] (initial)

8.3.1. The fact that the Facility submits a claim for payment does not relieve the Resident from liability for the cost of care for any days determined by the Program Administrators of the particular insurance coverage as non-covered, or for the Resident's portion of the liability as determined by the appropriate Program Administrators. Pre-certification of insurance, if required, is the responsibility of the Resident.

9. PERSONAL FINANCES.

9.1. Personal Funds Management. Resident is responsible to provide his or her personal funds, and Resident has the right to manage his or her personal funds. Resident may authorize the Facility, in writing, on a document provided by the Facility, to hold Resident's personal funds, and may revoke at any time the Facility's authorization by providing the Facility with a written notice signed and dated by Resident or Authorized Representative. If Resident authorizes the Facility to hold Resident's personal funds, the Facility shall hold, safeguard and account for Resident's personal funds in accordance with applicable provisions in the Admission Handbook. If the Facility has been appointed by the Social Security Administration as Representative Payee for the Resident's funds, then the Facility, and not the Resident's Authorized Representative, if any, shall have control over the Resident's funds. The Facility shall follow the policies and procedures as set forth by the Social Security Administration.

9.2. Refunds of Personal Funds. Any personal funds or valuables of Resident held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, such as any costs incurred by Facility to repair Resident's room for damages caused by Resident, within thirty (30) days after Resident's discharge or death. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law.

9.3. Refunds of Prepayments or Overpayments. Any prepayments or overpayments made by Resident and held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, after all claims have been adjudicated. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law. No interest shall accrue on any funds required to be refunded under this Agreement.

10. TERMINATION, TRANSFER OR DISCHARGE.

10.1. Resident Initiated. This Agreement remains in full force and effect until discharge of Resident regardless of payment source changes. The Facility requests a three (3) day advance written or oral notification of an impending discharge.

10.2. Facility Initiated. The Facility may terminate this Agreement and Resident's stay and transfer or discharge Resident if:

10.2.1. The transfer or discharge is necessary to meet Resident's welfare and Resident's needs cannot be met in the Facility;

10.2.2. Resident's health has improved sufficiently so that Resident no longer needs the services provided by the Facility;

10.2.3. The safety or health of individuals in the Facility is or otherwise would be endangered;

10.2.4. Resident has failed, after notice, to pay for (or to have paid or treated as paid under the Medicare or Medicaid Programs) charges for Resident's care and stay at the Facility; or

10.2.5. The Facility ceases to operate.

10.3. Notice and Waiver of Notice. The Facility will notify Resident and Authorized Representative at least thirty (30) days in advance of transfer or discharge, except in situations when appropriate plans that are acceptable to the Resident can be implemented earlier, and except in cases of emergencies, including those situations described in subparagraphs 10.2.1, 10.2.2, and 10.2.3 above, or when the Resident has not resided in the Facility for at least thirty (30) days. Then only such notice as is reasonable under the circumstances shall be provided.

10.4. Withdrawal Against Advice. In the event Resident withdraws from the Facility against the advice of his/her attending physician and/or without approval of the Facility, all of Facility's responsibilities for the care of Resident are terminated.

11. FACILITY RULES, REGULATIONS, POLICIES AND PROCEDURES.

Resident shall comply fully with all governmental laws and regulations, the provisions of this Agreement, and the Facility's rules, regulations, policies and procedures as published in the Facility's Admission Handbook or other documents or publications made available by the

Facility. The Facility reserves the right to amend or change its rules, regulations, policies and procedures. The Facility's rules, regulations, policies and procedures shall not be construed as imposing contractual obligations on the Facility or granting any contractual rights to Resident, and are subject to change from time-to-time.

12. PERSONAL AND OTHER PROPERTY.

12.1. Responsibility for Maintenance and Loss. Resident is responsible for furnishing and maintaining his or her own clothing and other items of property as needed or desired. Seasonal items and clothing must be removed timely to assure the safety and comfort of the Resident. The Facility is not responsible for the personal property / valuables or items belonging to the Resident. If damage or loss occurs to Resident's property, the Facility will investigate each incident of loss or damage.

12.2. Disposition and Storage Upon Resident's Death. Upon the Resident's death, Facility shall contact Resident's Authorized Representative and arrange for the disposition of the Resident's personal property. Facility is authorized to transfer Resident's personal property to the Authorized Representative. The Authorized Representative must acknowledge, in writing, the receipt of the personal property transferred to his or her custody by Facility. Facility, in its sole discretion, may move and place Resident's personal property into storage at Facility's expense. If property held in storage is not claimed within thirty (30) days, Facility shall donate or discard all unclaimed property.

12.3. Disposition and Storage Upon Resident's Transfer or Discharge. If Resident's personal property is not claimed or removed by the Authorized Representative following Resident's transfer or discharge, the Facility shall move and place Resident's personal property in storage until claimed. If Resident's personal property remains unclaimed after a thirty (30) day period in storage, the Facility may dispose of Resident's property. The Facility is not responsible for any damages incurred to Resident's property if storage becomes necessary.

12.4. Damage to Room or Facility Property. Resident or Resident's estate is responsible for any damages caused to the Facility property beyond normal wear and tear, and shall pay for the repair and replacement of damaged property, based on the actual charge or cost to the Facility for such repair or replacement.

13. RESIDENT RECORDS.

Resident consents to the release of Resident's personal and medical records maintained by the Facility for treatment, payment and operations as determined reasonably necessary by the Facility. Any such release may be to the Facility's employees, agents and to other health care providers from whom the Resident receives services, to third-party payors of health care services, to any MCO in which Resident may be enrolled, or to others deemed reasonably necessary by the Facility for purposes of treatment, payment and operations. Release of records for other purposes shall be done in accordance with applicable laws, with a specific authorization from the Resident where required. Authorized agents of the state or federal government, including the Long Term Care Ombudsman, may obtain Resident's records without the written consent or authorization of Resident.

14. TREATMENT AUTHORIZATION.

Resident authorizes the Facility to provide care and treatment consistent with the terms of this Agreement. Resident also authorizes the Facility to obtain all necessary clinical and/or financial information from the hospital or nursing facility from which Resident may be transferring.

15. DEATH OF RESIDENT.

Upon admission, Resident is required to designate a funeral home. This designation will remain in effect until otherwise notified in writing. In the event of Resident's death, the Facility shall notify the person(s) designated by Resident. The Facility is authorized to arrange for the transfer of Resident's body to the designated funeral home. Resident's estate is responsible for the payment of all costs associated with the transfer and funeral expenses. Resident shall notify the Facility of any changes of the person(s) or funeral home to be notified in the event of death.

16. CAPACITY OF RESIDENT AND GUARDIANSHIP.

If Resident is, or becomes, unable to understand or communicate, and is determined by Resident's Physician or the Facility's Medical Director / Designee after admission to be incapacitated, the Facility shall have the right, in the absence of Resident's prior designation of an authorized legal representative, or upon the unwillingness or inability of the legal representative to act, to commence a legal proceeding to adjudicate Resident incapacitated and to have a court appoint a guardian for Resident. The cost of the legal proceedings, including attorneys' fees, shall be paid by Resident or Resident's estate.

17. CLINICAL ISSUES RELATED TO AGING:

17.1. The Resident has been advised of the high risks and consequences associated with aging and impaired physical condition, including (but not limited to):

17.1.1. A high risk of skin breakdown and development of pressure ulcers secondary to significant time confined to bed or inability or unwillingness to eat and/or drink.

17.1.2. The risk of significant weight loss and dehydration if the Resident's physical condition is currently chronic or hereinafter deteriorates, which may diminish Resident's nutritional and hydration input.

17.1.3. The enhanced risk of falls and subsequent bruises, cuts or fractures, which then increases the already high risk of pressure ulcers.

17.1.4. The goal of the Facility is to strive for a restraint-free environment, and processes are implemented to pursue this goal. These processes recognize and protect the Resident's rights and ensure that restraints are safe and appropriate if they must be used.

17.1.5. The above risks, and others, are inherent with the aging process. We urge the

Resident and all family members to further acquaint themselves with the risk issues inherent with aging and an impaired physical condition.

18. REPORTING COMPLAINTS.

If Resident and/or Authorized Representative believe(s) that Resident is being mistreated in any way or Resident's rights have been violated by staff or another resident, Resident or Authorized Representative shall make his/her complaint known to Facility Administrator, in accordance with the Grievance Procedure reflected in the Admission Handbook and provide Facility with sixty (60) days to resolve the complaint satisfactorily to Resident and/or Authorized Representative before the Resident / Authorized Representative may pursue arbitration (or legal action for claims involving less than $25,000.00). This notice requirement is not intended to preclude Resident and/or Authorized Representative from filing a complaint with any appropriate governmental regulatory agency at any time.

19. MISCELLANEOUS PROVISIONS.

19.1. **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of South Carolina. / North Carolina.

19.2. **Severability.** The various provisions of this Agreement shall be severable one from another. If any provision of this Agreement is found by a court or administrative body of proper jurisdiction and authority to be invalid, the other provisions shall remain in full force and effect as if the invalid provision had not been a part of this Agreement.

19.3. **Captions.** The captions used in connection with the sections and subsections of this Agreement are inserted only for the purpose of reference. Such captions shall not be deemed to govern, limit, modify, or in any manner affect the scope, meaning or intent of the provisions of this Agreement, nor shall such captions be given any legal effect.

19.4. **Entire Agreement.** This Agreement, the Authorized Representative Agreement, the Arbitration Agreement, and the admission documentation represent the entire Agreement and understanding between the parties and supersedes, merges and replaces, all prior negotiations, offers, warranties and previous representations, understandings or agreements, oral or written, between the parties.

19.5. **Modifications.** The Facility reserves the right to modify unilaterally the terms of this Agreement to conform to subsequent changes in law, regulation or operations. To the extent reasonably possible, the Facility will give Resident and Resident's Authorized Representative thirty (30) days advance written notice of any such modifications. Resident may not modify this Agreement except by a writing signed by the Facility.

19.6. **Waiver of Provisions.** The Facility reserves the right to waive any obligation of Resident under the provisions of this Agreement in its sole and absolute discretion. No term, provision or obligation of this Agreement shall be deemed to have been waived by the Facility unless such waiver is in writing by the Facility. Any waiver by the Facility shall not be deemed a waiver of any other term, provision or obligation of this Agreement, and the other obligations of Resident and this Agreement shall remain in full force and effect..

20. ACKNOWLEDGMENTS.

20.1. Rate Schedule. Resident acknowledges the receipt of a copy of the Rate Schedule and the opportunity to ask questions about the Facility's charges.

20.2. Resident's Rights. Resident acknowledges being informed orally and in writing of Resident's Rights and further acknowledges having an opportunity to ask questions about those rights. The Notice of Rights of Nursing Facility Residents is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.

20.3. Advance Directives. Resident acknowledges being informed, orally and in writing, of the Facility's policy on advance directives and medical treatment decisions.

20.4. Bed Hold Policy – Readmission. Resident acknowledges being informed orally of the Facility's policy on readmission and bed hold. Resident further acknowledges having received in writing a copy of the readmission bed hold policy; and an opportunity to ask questions.

20.5. Agreement. Resident acknowledges that he/she has read and understands the terms of this Agreement, that the terms have been explained to him/her by a representative of the Facility, and that he or she has had an opportunity to ask questions about this Agreement, and has received a copy of this Agreement.

20.6. Smoke-Free / Tobacco-Free Policy. Resident acknowledges that he/she has read and understands that this Facility and campus are smoke-free and tobacco-free. The terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the Smoke-free /Tobacco-free Policy.

20.7. Camera Policy. Resident acknowledges that he/she has read and understands the Facility camera policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the camera policy.

20.8. Get a Lift Safe Resident Handling Program. Resident acknowledges that he/she has received an oral explanation and a copy of the safe resident handling program policy and procedures. Resident further acknowledges having an opportunity to ask questions about this policy.

20.9. Physical Device Policy. Resident acknowledges that he/she has read and understands the Facility physical device policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the physical device policy.

20.10. Admission Handbook. Resident acknowledges the receipt of a copy of the Admission Handbook and the opportunity to ask questions about Facility's policies

contained in the Admission Handbook. The Admission Handbook is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.

20.11. Consent to Care. Resident hereby consents to all routine care and services rendered in accordance with physician's orders. Resident also consents to student care from universities or other academic programs which are under contract with the facility unless the facility receives from the Resident/Authorized Representative a signed document of denial of student services.(Revised 10/2010).

20.12. Participation in Care Plan. Resident is encouraged to participate in the care planning process. Approval of the Resident Care Plan is the preferred manner in which consent for most treatment is obtained. There are certain specific procedures for which an individual consent form will be provided.

20.13. Consent to Photograph. Resident consents to pictures taken for identification purposes only.

20.14. Contents of Personal Medical Records. Resident understands and agrees that the designated record set concerning Resident is and will continue to be the property of the Facility, provided that Facility will not disclose the same to any person or party other than the Resident except as outlined in the Privacy Practices Notice. The designated record set is defined as the medical record in its entirety and the financial record including itemized charges. The following items are specifically excluded from the designated record set: incident reports, QA/QI reports, tracking forms, resident care assignment forms, shift to shift report forms, admission waiting list and financial "work papers."

20.15. Notification of Facility Symbols. Resident / Authorized Representative hereby acknowledge being informed of the use of signs and symbols which may be observed in this facility. For the resident's safety and comfort, the facility may post on a doorway leading into a resident's room a symbol for type of lift device to be used or a star alerting staff to a potential fall risk. Other symbols may be used from time to time which may designate and alert staff to a specific need. You or your Authorized Representative may opt out of having symbols posted by signing a waiver of release from use of facility designated symbols.

20.16. Competency. Resident declares that he or she retains capacity and is competent, has never been adjudged or determined to lack capacity or competence, and knows of no petition pending to adjudicate his or her lack of capacity or competence. Alternatively, if the Resident has been or should be deemed to lack capacity or competence, then Resident's Authorized Representative declares that he or she has been given authority by the Resident when competent to ask on behalf of the Resident, and/or is qualified to act as Resident's surrogate by reason of special care and concern for the Resident, familiarity with the Resident's personal values, reasonable availability, and willingness to serve.

20.17. Scope of Care. Resident acknowledges that routine nursing services do not include: continuous one-on-one care or CNA services when required by Resident's Care

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plan; care for certain high acuity conditions, such as ventilator dependent care; dialysis services; treatment for drug and alcohol conditions; or psychiatric care.

21. ARBITRATION.

WITH REGARD TO ALL MONETARY CLAIMS ARISING BETWEEN THE FACILITY AND RESIDENT / AUTHORIZED REPRESENTATIVE, TO THE EXTENT THAT THEY ARE FOR MORE THAN $25,000.00, ARBITRATION (PURSUANT TO THE FEDERAL ARBITRATION ACT) IS MANDATORY (SUBJECT TO THE "OPT OUT" PROVISIONS SET FORTH IN PARAGRAPH 16 OF THE ARBITRATION AGREEMENT), BINDING AND FINAL. THE EXACT TERMS FOR ARBITRATION ARE SET FORTH IN A SEPARATE DOCUMENT OF EVEN / RECENT DATE, ENTITLED "ARBITRATION AGREEMENT" AND ARE INCORPORATED HEREIN BY REFERENCE. WITH REGARD TO ANY NONMONETARY CLAIM, OR ANY CLAIM FOR LESS THAN $25,000.00, ARBITRATION SHALL NOT BE REQUIRED.

22. BINDING EFFECT.

This Agreement shall be binding upon all parties hereto and upon their respective heirs, personal representatives, successors and assigns.

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, have signed this Agreement this 2ND day of Jan, 2013

RESIDENT / AUTHORIZED REPRESENTATIVE:

Jody P. Davis

Hilda K. Hanby-Stott — Signature / Date

Printed Resident Name

Printed Authorized Representative — Signature / Date

Niece

Relationship

FACILITY STAFF / WITNESS:

White Oak [signature], Inc. Date: 1/2/13

By: Nancy P. Sprouse — [signature]

Staff Printed Name and Title — Staff Signature / Witness

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

RECEIVED
JAN 23 2019
SC Court of Appeals

Case No. 2016-001732

Hilda Stott, individually and as Personal Representative of the Estate of Jolly P. Davis, deceased, and as Personal Representative of the Statutory Beneficiaries, ...Respondents,

v.

White Oak Manor, Inc.; White Oak Management, Inc.; and White Oak Manor-Spartanburg, Inc. d/b/a White Oak of Spartanburg, ... Appellants.

CERTIFICATE OF COUNSEL

Counsel certifies that this Supplemental Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

THE WARD LAW FIRM, P.A.
Attorneys for Appellants

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January 18, 2019.