

STATE OF SOUTH CAROLINA)
)
 COUNTY OF CHARLESTON)
)
 Laverne Mitchell as Personal Representative of)
 the Estate of Florine Blake,)
 _____)
 Plaintiff,)
 vs.)
 Sandpiper Rehab & Nursing-Delaware, LLC d/b/a)
 Sandpiper Rehab & Nursing , and Annette)
 Goodwin,)
 _____)
 Defendant.)

IN THE COURT OF COMMON PLEAS

CASE NO.: 2019-CP-10-00966

MOTION AND ORDER INFORMATION

FORM AND COVERSHEET

Plaintiff's Attorney: <u>D. Nathan Hughey, Bar No. 68409</u> Address: <u>PO Box 348, Mt. Pleasant, SC 29465</u> Phone: <u>843-881-8644</u> Fax <u>1-888-884-8311</u> E-mail: <u>nate@hugheylawfirm.com</u> Other: _____	Defendant's Attorney: <u>Kevin R. Horton, Bar No. _____</u> Address: <u>126 Seven Farms Dr, Suite 260, Charleston, SC 29492</u> Phone: <u>843-606-5635</u> Fax: <u>843-654-4095</u> E-mail: <u>khorton@smythwhitley.com</u> Other: _____
<input checked="" type="checkbox"/> MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III) <input type="checkbox"/> FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III) <input type="checkbox"/> PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)	
SECTION I: Hearing Information	
Nature of Motion: <u>Motion to Compel</u> Estimated Time Needed: <u>25 Minutes</u> Court Reporter Needed: <input checked="" type="checkbox"/> YES / <input type="checkbox"/> NO	
SECTION II: Motion/Order Type	
<input checked="" type="checkbox"/> Written motion attached <input type="checkbox"/> Form Motion/Order I hereby move for relief or action by the court as set forth in the attached proposed order.	
_____ Signature of Attorney for <input checked="" type="checkbox"/> Plaintiff / <input type="checkbox"/> Defendant	<u>May 7, 2019</u> Date submitted
SECTION III: Motion Fee	
<input type="checkbox"/> PAID – AMOUNT: \$ _____ <input type="checkbox"/> EXEMPT: (check reason)	
<input type="checkbox"/> Rule to Show Cause in Child or Spousal Support <input type="checkbox"/> Domestic Abuse or Abuse and Neglect <input type="checkbox"/> Indigent Status <input type="checkbox"/> State Agency v. Indigent Party <input type="checkbox"/> Sexually Violent Predator Act <input type="checkbox"/> Post-Conviction Relief <input type="checkbox"/> Motion for Stay in Bankruptcy <input type="checkbox"/> Motion for Publication <input type="checkbox"/> Motion for Execution (Rule 69, SCRPC) <input type="checkbox"/> Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions Name of Court Reporter: _____ <input type="checkbox"/> Other: _____	
JUDGE'S SECTION	
<input type="checkbox"/> Motion Fee to be paid upon filing of the attached order. <input type="checkbox"/> Other: _____	JUDGE CODE _____ Date: _____
CLERK'S VERIFICATION	
Collected by: _____ Date Filed: _____ <input type="checkbox"/> MOTION FEE COLLECTED: \$ _____ <input type="checkbox"/> CONTESTED – AMOUNT DUE: \$ _____	

SCCA 233 (11/2003)

3. Care and services agreement;
 4. Healthcare directives and special information, *e.g.*, advance directive information, do-not-resuscitate(DNR) orders, allergies;
 5. Incidents involving the resident; (I)
 6. Medical treatment;
 7. Orders, including telephone and standing orders, for all medication, care, services, therapy, procedures, and diet from physicians or other legally authorized healthcare providers, which shall be completed prior to, or at the time of admission, and subsequently, as warranted;
 8. Individual Care Plan; (I)
 9. Provisions for routine and emergency medical care, to include the name and telephone number of the resident's physician;
 10. Assessments and progress notes, *e.g.*, dietary, activity, therapy;
 11. Record of administration of each dose of medication; (I)
 12. Record of the use of restraints, if applicable, including time, type, reason and authority for applying; (I)
 13. Treatment, procedure, wound care report (dictated or written into the record after treatment, procedure, or wound care) to include at least: (I)
 - a. Description of findings;
 - b. Techniques utilized to perform treatments and procedures;
 - c. Specimens removed, if applicable;
 - d. Name of provider;
 14. Progress notes generated by physicians and healthcare professionals;
 15. Notes of observation, including temperature, pulse, respiration, blood pressure and weight when indicated by physician's orders or by a change in the resident's condition; (I)
 16. Special procedures and preventive measures performed, *e.g.*, isolation for symptoms, diagnosis, and/or treatment of infectious conditions including but not limited to tuberculosis, influenza, pneumonia, therapies;
 17. Reports of all laboratory, radiological, and diagnostic procedures along with tests performed and the results appropriately authenticated; (I)
 18. Consultations by physicians or other healthcare professionals;
 19. Photograph of resident, if the resident or his or her responsible party approves;
 20. Date and hour of discharge or transfer, as applicable;
 21. Discharge and/or transfer summary, including care and condition at discharge or transfer, date and time of discharge or transfer, instructions for self-care, instructions for obtaining post-treatment or procedure emergency care, and signature of physician authorizing discharge or transfer;
 22. Date and circumstances of death, as applicable.
- C. Except as required by law, records may contain written and interpretative findings and reports of diagnostic studies, tests, and procedures, *e.g.*, interpretations of imaging technology and video tapes without the medium itself.

- D. Unauthorized alterations of information in the record are prohibited. Corrections to entry errors shall include the date the correction was made and the signature of the individual making the correction.
- E. Records shall be maintained on all outpatients and shall be completed immediately after treatment is rendered. These records shall contain sufficient identification data, a description of what was done and/or prescribed for the outpatient and shall be signed by the attending physician. When an outpatient is admitted as a resident of the facility, all of the outpatient records shall be made a part of his or her permanent resident record.

802. Physician Orders (II)

A. Physician Orders. The resident's physician shall sign and date all treatment, care, and medication orders, including standing orders.

1. The use of a rubber stamp signature or electronic representation is acceptable under the following conditions:

a. The physician whose signature the rubber stamp or electronic representation denotes is the only one who has possession of the stamp or electronic representation and is the only one who uses it; and

b. The physician places in the administrative offices of the facility a signed statement to the effect that he or she is the only one who has the stamp or electronic representation and is the only one who will use it.

2. The use of rubber stamp signatures is not permissible on orders for "controlled substances."

3. Consultative reports and diagnostic procedures requested by a physician, *e.g.*, radiological, laboratory reports, shall be acknowledged by the physician signature. (I)

B. Verbal Orders. (I)

1. All orders for medication, treatment, care and diet shall be signed and dated by the individual receiving the orders.

2. Verbal orders received shall include the date of the order, description of the order, and identification of the physician or other legally authorized healthcare provider and the individual receiving the order.

3. Verbal orders in other specialized departments or services, as authorized in facility policy and procedures, may be received by those departments or services, *e.g.*, orders pertaining to physical therapy may be received by a physical therapist.

4. A committee (to include representation by physicians treating residents at the facility, a pharmacist, and the Director of Nursing) shall identify and list categories of diagnostic or therapeutic verbal orders (associated with any potential hazard to the resident) that shall be authenticated by the prescriber within a limited time period (within two (2) days after the order is given). A copy of this list shall be maintained at each staff work area.

a. Verbal orders designated by the committee as requiring authentication within a limited time period shall be authenticated and countersigned and dated by the prescriber or designee within a time period defined in facility policies and procedures, but in no case more than two (2) days after the order was given.

b. All other verbal orders shall be countersigned and dated by the prescriber or his or her designee within sixty (60) days.

c. Verbal orders for restraints shall be authenticated in the manner prescribed in Section 1012.B.

C. Standing Orders. (I)

1. Physician's standing orders, except for restraints, are permissible but shall take into consideration specific circumstances such as medication allergies, gender-specific orders, and the pertinent physical condition of the resident, when appropriate.

2. Over-the-counter medications may be utilized on a physician's standing orders. Controlled or legend medications shall be an individual order reduced to writing on the physician's order sheet as either a routine or *pro re nata* (prn) order and shall not be utilized on a physician's standing order unless the medications have been identified by the

facility as those commonly used in routine situations. Each standing order shall include on the order sheet the following, as appropriate:

a. Name of the medication;

b. Strength of the medication;

c. Specific dose (or dose range) of the medication;

d. Mode of administration;

e. Reason for administration;

f. Time interval between doses for administering the medication; and

g. Maximum dosage or number of times to be administered in a specific time period.

3. Standing orders shall be signed and dated by the prescribing physician initially and reviewed at least annually thereafter.

D. Standing orders regarding restraints are prohibited.

803. Individual Care Plan (ICP) (II)

A. The facility shall develop an ICP with participation by, and as evidenced by the signatures of the resident or responsible party, or documentation that the facility attempted to obtain the signatures, and an interdisciplinary team of qualified individuals, within fourteen (14) days of admission. The ICP shall be reviewed and/or revised as changes in resident needs occur, but not less than quarterly by the interdisciplinary team.

B. The ICP shall describe:

1. The needs of the resident, including the services that are to be furnished, *i.e.*, what assistance, how much, who will provide the assistance, how often, and when;

2. Advance directives and healthcare power-of-attorney, as applicable;

3. Recreational and social activities that are suitable, desirable, and important to the resident;

4. Dietary needs and preferences of resident as approved by a physician;

5. Discharge planning, to include assessing continuing care needs and developing a plan designed to assure the resident's needs will be met after discharge or transfer.

805. Electronic Resident Records

A. Electronic records are subject to all of the standards of this regulation.

- B. A facility that maintains electronic records shall:
1. Retain the hard copy originals of any materials that cannot be electronically stored;
 2. Employ an off-site backup storage system as protection in the event that the on-site system is damaged or destroyed;
 3. Use an imaging mechanism that is able to copy documents with signatures;
 4. Assure that records, once put in electronic form, are unalterable.
- C. Electronic signatures may be used any place in the resident or outpatient record that requires a signature, provided signature identification can be verified and an electronic signature may be legally used.
- d. Electronic authorization shall be limited to a unique identifier (confidential code) used only by the individual making the entry to preclude the improper or unauthorized use of any electronic signature.

As well as those required by the HITECH act:

[1] The HITECH Act requires the Defendant to keep and produce audit trails.

Section 170.302(r) requires:

– Record actions. Record actions related to electronic health information in accordance with the standards specified in section 170.210(b).

– Generate audit log. Enable a user to generate an audit log for specific time period and to sort entries in the audit log according to any of the elements specified in the standard at section 170.210(b).

As indicated, a metadata or an audit trail is a mandatory log containing the identity of every individual accessing a medical record, the time and date of the record accessed, identification of the records accessed, the portion of the records accessed and any modifications to the records made. 20 1CFR part 11.

Stage II of the certification criteria for meaningful use includes section 170.314(b).

(3) audit reports. This section requires the ability to enable a user to create an audit report for a specific time period and to sort entries in the Autolog according to each of the data specified in the standards at section 170.210(e).

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D. Nathan Hughey (SC Bar #68409)
A. Stuart Hudson (SC Bar #71691)
HUGHEY LAW FIRM, LLC
1311 Chuck Dawley Blvd., Suite 201
Post Office Box 348
Mt. Pleasant, South Carolina 29465
(843) 881-8644 (P)
(888) 884-8311 (F)
nate@hugheylawfirm.com
stuart@hugheylawfirm.com
brad@hugheylawfirm.com

Attorneys for the Plaintiff

S/2, 2019
Mt. Pleasant, South Carolina

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by mailing, e-mailing, facsimile, or hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 8th day of May, 2019.

Annifer Wilson



Hughey Injury Lawyers

1311 Chuck Dawley Blvd. Ste. 201
Post Office Box 348
Mt. Pleasant, SC 29464
P: 843-881-8644
F: 1-888-884-8311

Reply to: D. Nathan Hughey
nate@hugheyfirm.com

May 7, 2019

Honorable Julie J. Armstrong
Charleston County Clerk of Court
100 Broad Street, Suite 106
Charleston, SC 29401

Re: Laverne Mitchell as Personal Representative of the Estate of Florine Blake v. Sandpiper Rehab & Nursing-Delaware, LLC d/b/a Sandpiper Rehab & Nursing, and Annette Goodwin
Case No. 2019-CP-10-0966

Dear Ms. Armstrong:

Enclosed please find for filing a Motion Cover Sheet, Notice of Motion and Motion to Compel in regards to the above referenced matter along with appropriate copies. I have also enclosed this firm's check in the amount of \$25.00 for the filing fee. If you could be so kind as to file the originals and return a filed stamped copy back to me in the self-addressed stamped envelope it would be greatly appreciated. If you have any questions or concerns, do not hesitate to contact me.

If you have any questions, please let me know.

With kind regards,

Yours truly,

A handwritten signature in black ink, appearing to be 'D. Nathan Hughey', written in a cursive style.

D. Nathan Hughey

DNH/jw
Enclosures
CC: Kevin Horton, Esquire