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A. Todd Darwin
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Neville Holcombe, 1902-1983
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December 10, 2021

RECEIVED

Dec 10 2021

SC Court of Appeals

Via Email: ctappfilings@sccourts.org
Jenny Abbott Kitchings
Clerk of Court, South Carolina Court of Appeals
PO Box 11629
Columbia, SC 29211

RE: Teresa Dalton as Personal Representative of the Estate of Ethel Ruckart v. Mount Pleasant Manor and Bruce White
Appellate Case No.: 2020-001117
Our File No.: 15725

Dear Madam Clerk:

It has come to my attention upon reviewing the Record on Appeal than one document which appears periodically throughout the Record on Appeal is of very poor quality. I believe this resulted from the same document being copied and filed on multiple occasions, each making it more difficult to read. I have attached a cleaner copy of the document (Health Care Power of Attorney and Advance Directive Regarding a Natural Death).

Pursuant to Rule 212(b), SCACR, I consulted with counsel for the Respondent and received his consent to supplement the record with a cleaner copy of this document. I have attached a copy of our communication evidencing his consent.

I understand that Rule 212(c), SCACR requires that I file this document by way of an Appendix to the Record on Appeal. I am happy to do that, but before I take that step, I would like to speak with someone in your office to make sure I do this correctly.

If you could have someone contact me to discuss this matter, I would be most appreciative.

Sincerely,

W. McElhane White

WMW/lc

cc: Jordan C. Calloway, Esq. (via email)
D. Nathan Hughey, Esq. (via email)
A. Stuart Hudson, Esq. (via email)
Bradley H. Banyas, Esq. (via email)

Lori Copeland

From: Jordan Calloway <jordan@mcgowanhood.com>
Sent: Friday, December 10, 2021 1:16 PM
To: Mac White; nate@hugheylawfirm.com; stuart@hugheylawfirm.com; brad@hugheylawfirm.com
Cc: Lori Copeland
Subject: Re: Teresa Dalton v. Mount Pleasant Manor (2020-001117)

We consent.

Thanks,

Jordan Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800

From: Mac White <mwhite@holcombebomar.com>
Sent: Friday, December 10, 2021 1:02 PM
To: nate@hugheylawfirm.com <nate@hugheylawfirm.com>; stuart@hugheylawfirm.com <stuart@hugheylawfirm.com>; brad@hugheylawfirm.com <brad@hugheylawfirm.com>; Jordan Calloway <jordan@mcgowanhood.com>
Cc: Lori Copeland <lcopeland@holcombebomar.com>
Subject: RE: Teresa Dalton v. Mount Pleasant Manor (2020-001117)

Gentlemen:

I noticed when looking at the ROA that the copies of the HCPOA were extremely blurry and probably cannot be read by the court. I think that happened after multiple copies of a fairly poor document were made.

Lori called the court about this and it was suggested that I ask for your consent to supplement the ROA under Rule 212(b) to file a cleaner copy. I have attached what I would like to file. Can I have your consent to do that?

Thanks.

Mac

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From: Spencer, Shelby <sspencer@sccourts.org>

Sent: Friday, December 10, 2021 12:47 PM

To: nate@hugheyfirm.com; stuart@hugheyfirm.com; brad@hugheyfirm.com; Mac White <mwhite@holcombemom.com>; jcalloway@mcgowanhood.com

Subject: Teresa Dalton v. Mount Pleasant Manor (2020-001117)

Dear Counsel,

Attached is a copy of this Court's letter. If you have any questions or concerns, please do not hesitate to contact our office.

Warmly,

Shelby Spencer

Appeals Specialist II

SC Court of Appeals

1220 Senate Street

Columbia, SC 29201

803.734.1890

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**HEALTH CARE POWER OF ATTORNEY  
AND  
ADVANCE DIRECTIVE REGARDING A NATURAL DEATH**

**1. Designation of Health Care Agent.**

I, ETHEL K. RUCKART, being of sound mind, hereby appoint the following person to ~~serve as my health care agent to act for me and in my name (in any way I could act in person) to make health care decisions for me~~ as authorized in this document. My designated health care agent shall serve alone.

|                        |                                        |
|------------------------|----------------------------------------|
| Name:                  | TERESA R. DALTON                       |
| Home Address:          | 54 Brandon Way<br>Georgetown, SC 29440 |
| Home Telephone Number: | (336) 906-5105                         |

**2. Effectiveness of Appointment.**

A. **Appointment with Regard to General Authority.** My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if my attending physician(s) determines that I lack capacity to make or communicate decisions relating to my health care and will continue in effect during that incapacity, or until my death, except that if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

B. **Current Appointment with Regard to Medical Records.** Regardless of whether one or more physicians have made a determination that I lack capacity to make or communicate decisions related to my health care, I authorize all health care providers (including physicians, nurses, and all other persons and entities) who may have provided, or are providing, me with any type of health care, to disclose, without obtaining further authorization, all of my protected health information to my health care agent. This provision is intended to authorize my health care providers to disclose protected health information about me to my health care agent to allow my health care agent to review any determinations made by physicians concerning my capacity.

**3. Revocation.**

Any time while I am competent, I may revoke this document in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician, health care agent or to any of my health care providers.

**4. General Statement of Authority Granted.**

I grant to my health care agent full power and authority to make decisions for me regarding my health care. In exercising this authority, my health care agent shall follow my desires as stated in this document or otherwise expressed by me or known to my health care agent. If my health care agent cannot determine the choice I would want made, then my health care agent shall make a choice for me based upon what my health care agent believes to be in my best interests. My health care agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, except as specifically limited below, my health care agent is given the power and authority to:

- A. Request, review and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to ~~the disclosure of this information.~~
- B. Employ or discharge my health care providers.
- C. Consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility or other health care facility.
- D. Consent to and authorize my admission to and retention in a facility for the care or treatment of mental illness.
- E. Consent to and authorize the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."
- F. Give consent for, withdraw consent for or withhold consent for X-ray, anesthesia, medication, surgery and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.
- G. Provide my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.
- H. Take any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering and acknowledging any agreement, release, authorization or other document that may be necessary, desirable, convenient or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Statement of Desires Regarding Life-Prolonging Measures.

With respect to life-prolonging measures, if my attending physician determines (i) that I lack the capacity to make or communicate health care decisions and that I will never regain that capacity and (ii) that my present condition as confirmed by a physician other than my attending physician is one of the following:

A. I have an incurable or irreversible condition that will result in my death within a relatively short period of time, I direct the following: (Initial to the left only ONE of the three options below)

\_\_\_\_\_ (1) Grant of Discretion to Health Care Agent. I authorize my health care agent to make decisions for me regarding life-prolonging measures. I do not want my life to be prolonged by life-prolonging measures if my health care agent believes the burdens of such measures outweigh the expected benefits. I want my health care agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions for me concerning life-prolonging measures.

OR

ERN  
\_\_\_\_\_ (2) Directive to Withhold or Withdraw Treatment. I do not want my life to be prolonged, and I direct that life-prolonging measures shall be withheld or discontinued notwithstanding any directions of my health care agent to the contrary. However, I DO want to receive artificial nutrition and hydration \_\_\_\_\_ (You MUST initial to receive artificial nutrition and hydration).

OR

\_\_\_\_\_ (3) Directive for Maximum Treatment. I do not authorize my health care agent to withdraw, withhold or discontinue any life-prolonging measures. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery or the cost of the procedures.

B. I become unconscious and, to a high degree of medical certainty, will never regain my consciousness, I direct the following: (Initial to the left only ONE of the three options below)

\_\_\_\_\_ (1) Grant of Discretion to Health Care Agent. I authorize my health care agent to make decisions for me regarding life-prolonging measures. I do not want my life to be prolonged by life-prolonging measures if my health care agent believes the burdens of such measures outweigh the expected benefits. I want my health care agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions for me concerning ~~life-prolonging measures.~~

---

OR

Est \_\_\_\_\_ (2) Directive to Withhold or Withdraw Treatment. I do not want my life to be prolonged, and I direct that life-prolonging measures shall be withheld or discontinued notwithstanding any directions of my health care agent to the contrary. However, I DO want to receive artificial nutrition and hydration . \_\_\_\_\_ (You MUST initial to receive artificial nutrition and hydration).

OR

\_\_\_\_\_ (3) Directive for Maximum Treatment. I do not authorize my health care agent to withdraw, withhold or discontinue any life-prolonging measures. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery or the cost of the procedures.

C. I suffer from advanced dementia or any other condition resulting in the substantial loss of cognitive ability and that loss, to a high degree of medical certainty, is not reversible, I direct the following: (Initial to the left only ONE of the three options below)

\_\_\_\_\_ (1) Grant of Discretion to Health Care Agent. I authorize my health care agent to make decisions for me regarding life-prolonging measures. I do not want my life to be prolonged by life-prolonging measures if my health care agent believes the burdens of such measures outweigh the expected benefits. I want my health care agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions for me concerning life-prolonging measures.

OR

EKA

\_\_\_\_\_ (2) Directive to Withhold or Withdraw Treatment. I do not want my life to be prolonged, and I direct that life-prolonging measures shall be withheld or discontinued notwithstanding any directions of my health care agent to the contrary. However, I DO want to receive artificial nutrition and hydration. \_\_\_\_\_ (You MUST initial to receive artificial nutrition and hydration)

OR

\_\_\_\_\_ (3) Directive for Maximum Treatment. I do not authorize my health care agent to withdraw, withhold or discontinue any life-prolonging measures. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery or the cost of the procedures.

In following my directive set forth above, my health care providers shall take reasonable steps to keep me as clean, comfortable and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

6. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Paragraph 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

7. Reliance of Third Parties on Health Care Agent.

- A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns or personal representatives for actions or omissions in reliance on that authority or those representations.
- B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this

document are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns and personal representatives. The authority of my health care agent pursuant to this document shall be superior to and binding upon my family, relatives, friends and others.

8. Miscellaneous Provisions.

- A. Revocation of Prior Powers of Attorney and Living Wills. I revoke any prior health care power of attorney and advance directives for a natural death ("living wills"). The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this document shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.
- ~~B. Jurisdiction, Severability and Durability. This document is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this document are severable, so that the invalidity of one or more powers shall not affect any others. This document shall not be affected or revoked by my incapacity or mental incompetence.~~
- C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.
- D. No Civil or Criminal Liability. No act or omission of my health care agent or of any other person, entity, institution or facility acting in good faith in reliance on the authority of my health care agent pursuant to this document shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or a lack of professional competence. My health care agent and providers shall not be liable to me, my family, my estate, my heirs or my personal representative for following the instructions regarding withholding or withdrawing of life-prolonging measures I give in this document. Any person, entity, institution or facility against whom criminal or civil liability is asserted because of conduct authorized by this document may interpose this document as a defense.
- E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this document.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document and understand the full import of this grant of powers to my health care agent. I am aware and understand that this document sets forth my wishes concerning the future conditions under which life-prolonging measures may be withheld or discontinued in certain conditions in accordance with my advance instructions.

This the 25 day of September, 2013.

Ethel K. Ruckart (SEAL)  
ETHEL K. RUCKART

I hereby state that the principal, ETHEL K. RUCKART, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing document in my presence, that I am not related to the principal by blood or marriage and that I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: Sept 25, 2013

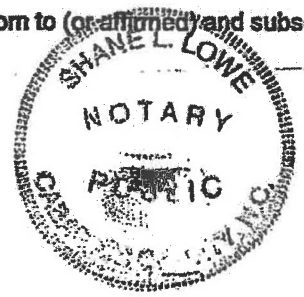
Witness: Debbie Little

Date: Sept 25, 2013

Witness: Lori A. Helms

NORTH CAROLINA  
GUILFORD COUNTY

Sworn to (or affirmed) and subscribed before me this day by: ETHEL K. RUCKART



Debbie Little  
(type/print name of witness)

Lori A. Helms  
(type/print name of witness)

Date: September 25, 2013  
(Official Seal)

Shane L. Lowe  
Signature of Notary Public

Shane L. Lowe, Notary Public  
Printed or typed name

My commission expires: March 8, 2017