IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
GREENVILLE DIVISION

JOEY MONTRELL CHANDLER **PLAINTIFF**

V. **NO. 4:15-CV-102-DMB-DAS**

WEXFORD HEALTH, et al. **DEFENDANTS**

MEMORANDUM OPINION

Before the Court is the defendants' motion for summary judgment. Doc. #45.

I
Procedural History and Relevant Background

On or about August 11, 2015, Joey Montrell Chandler filed a complaint in this Court against Wexford Health; the Mississippi Department of Corrections ("MDOC"); MDOC officials Marshall Fisher, Christopher Epps, and Jerry Williams; and physicians Juan Santos, Paul Madubuonwu, John Hochburg, Lorenzo Cabe, "Dr. Lehman," "Dr. Brown," and Gloria Perry. Doc. #1 at 1–2, 5–6. At the time he filed his complaint, Chandler was incarcerated at the Mississippi State Penitentiary in Parchman, Mississippi. *Id*. at 1.

In his complaint, Chandler alleged the defendants denied him adequate care for several medical conditions, including back pain, foot pain, and a bacterial infection allegedly causing diarrhea and "fecal leakage." *Id*. at 3–4, 14–16. On or about March 9, 2016, Chandler filed a motion to amend seeking to add Centurion of Mississippi as a defendant. Doc. #9. The motion to amend was granted on April 13, 2016. Doc. #11.

A *Spears*[1] hearing was held on April 14, 2016. Doc. #12. On July 20, 2016, United

[1] *See Spears v. McCotter*, 766 F.2d 179 (5th Cir. 1985).

States Magistrate Judge David A. Sanders issued a Report and Recommendation recommending that Chandler's "claims regarding denial of adequate medical treatment should be dismissed for failure to state a claim upon which relief could be granted. In addition, [Chandler's] claim of retaliation against Emmitt Sparkman should be dismissed for failure to exhaust administrative remedies."[2] Doc. #16 at 10.

Chandler acknowledged receipt of the Report and Recommendation on July 26, 2016. Doc. #18. On or about July 27, 2016, Chandler filed an untitled document addressed to Judge Sanders stating:

> On July 21, 2016 at about 9:00 am Supt. Earnest Lee allow Lt Nathan Harris to take my walking cane for no reason on penal logical interest. This action was ill will because of my ongoing litigation. Attach is a copy of ARP in which I will give MDOC 14 days to return my medical prescribed can used during SI Joint flares. If MDOC fails to comply I will file motion in the court immediately because other inmates are having to help around.

Doc. #17 at 1.[3]

On or about October 8, 2016, Chandler filed a document titled, "Plaintiff's Supplemental Objections." Doc. #19. On or about February 2, 2017, Chandler filed a "Motion for Leave to File an Amended Complaint Objection." Doc. #20. Lastly, on or about March 1, 2017, Chandler filed a "2nd Objection Amendment under Rule 15(a)," which in part is a motion to amend. Doc. #21.

On July 11, 2017, this Court rejected the Report and Recommendation as moot, granted Chandler's motion to amend, and directed him to file "a single amended complaint with the

[2] The Report and Recommendation notes Chandler's allegation "that, shortly after he filed suit, Deputy Commissioner Emmitt Sparkman asked him to dismiss it, but he would not." Doc. #16 at 5.

[3] Chandler attached to this filing a document entitled, "Administrative Remedy Request." *See* Doc. #17 at 2.

amendments allowed by this order." Doc. #22 at 4. On or about August 4, 2017, Chandler filed an amended complaint stating that he "would request the court to add Defendants: Superintendant Earnest Lee at Parchman State Prison and Medical Director Hendrik Kuiper and to maintain all initial defendants." Doc. #24 at 1. On February 15, 2018, Judge Sanders granted Chandler's motion to amend but noted that "[a]s the amended complaint neither names any other defendants nor describes any other claims, the plaintiff must intend for his 'amended complaint' to be a supplement to his original complaint." Doc. #26 at 1. On March 7, 2018, Judge Sanders ordered that process issue for Wexford Health, Santos, Madubuonwu, Perry, Brown, Cabe, Hochburg, Lehman, and Kuiper.[4] Doc. #30.

In his amended complaint, Chandler claims that the defendants failed to provide him with adequate medical care for (1) sacroiliac ("SI") joint dysfunction, which causes pain in his lower back, leg, and foot; (2) bone spurs and plantar fasciitis;[5] (3) a recurring infection of his tonsil; (4) costochondritis,[6] which causes pain in his chest and shoulder; and (5) shoulder pain (which medical providers suspect is related to costochondritis). Doc. #24 at 4. Chandler also claims that the defendants failed to respond to his letters and grievances regarding his conditions and ignored medical orders. *Id*. at 18–19. Further, Chandler alleges that Lee improperly searched his belongings and forced him and other unwell inmates to carry a heavy load of around seventy-five pounds, despite medical orders that Chandler not lift more than ten pounds, *id*. at 14–15; and

[4] On or about May 4, 2018, Chandler sought to reissue process to Wexford Health Services and Centurion of Mississippi due to incorrect addresses. Doc. #41.

[5] Plantar fasciitis is "inflammation of the plantar fascia, most usually noninfectious, and often caused by an overuse mechanism; elicits foot and heel pain." STEDMAN'S MEDICAL DICTIONARY 322870 (2014).

[6] Costochondritis is "inflammation of one or more costal cartilages, characterized by local tenderness and pain of the anterior chest wall that may radiate …." *Id*. at 208810.

that medical personnel laughed at his condition and suggested that they "cut his head off to relieve him of pain and litigation," *id*. at 20–21.

On June 6, 2018, the defendants filed a motion for summary judgment. Doc. #45. On or about June 20, 2018, Chandler responded in opposition, Doc. #52; and eight days later, the defendants replied, Doc. #55.

II
Standard of Review

"Summary judgment is proper only when the record demonstrates that no genuine issue of material fact exists and the movant is entitled to judgment as a matter of law." *Luv N' Care, Ltd. v. Groupo Rimar*, 844 F.3d 442, 447 (5th Cir. 2016). "A factual issue is genuine if the evidence is sufficient for a reasonable jury to return a verdict for the non-moving party and material if its resolution could affect the outcome of the action." *Burton v. Freescale Semiconductor, Inc.*, 798 F.3d 222, 226 (5th Cir. 2015) (quotation marks omitted). In evaluating a motion for summary judgment, a court must "consider the evidence in the light most favorable to the nonmoving party and draw all reasonable inferences in its favor." *Edwards v. Cont'l Cas. Co.*, 841 F.3d 360, 363 (5th Cir. 2016).

In seeking summary judgment, "[t]he moving party bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of the record which it believes demonstrate the absence of a genuine issue of material fact." *Nola Spice Designs, L.L.C. v. Haydel Enters., Inc.*, 783 F.3d 527, 536 (5th Cir. 2015) (quotation marks and alterations omitted). If the moving party satisfies this burden, "the non-moving party must go beyond the pleadings and by her own affidavits, or by the depositions, answers to interrogatories, and admissions on file, designate specific facts showing that there is a genuine issue for trial."

Id. (quotation marks omitted). "Where the nonmoving party bears the burden of proof at trial, the moving party satisfies this initial burden by demonstrating an absence of evidence to support the nonmoving party's case." *Celtic Marine Corp. v. James C. Justice Cos., Inc.*, 760 F.3d 477, 481 (5th Cir. 2014).

III
Analysis

Essentially, Chandler claims that the defendants provided him with inadequate medical treatment for several of his ailments which evinced deliberate indifference and that several of his grievances complaining of his improper treatment were rejected. *See* Doc. #24 at 4, 8, 18–19. Specifically, Chandler claims he endured an unsuccessful tonsillectomy, *id*. at 6; a delayed referral to specialists and prison medical staff's refusal to follow specialists' treatment plans, *id*. at 7–10, 13; generalized delays in providing medical treatment, *id*. at 11–12; carrying seventy-five pounds of weight after prison security demanded he pack and move his property despite medical professionals' order that he not lift more than ten pounds, *id*. at 14–17; improper handcuffing and confiscation of his walking cane, *id*. at 17; doctors' joking that they should "cut his head off," *id*. at 21; and the failure to prescribe him the proper medication, *id*. at 23.

A. No Constitutional Right to Prison Administrative Grievance Procedure

Chandler brings this case under 42 U.S.C. § 1983, which provides a federal cause of action against every person who, under color of state authority, causes the "deprivation of any rights, privileges, or immunities secured by the Constitution and laws …." To begin, there is no constitutional entitlement to the existence—or adequacy—of prison grievance procedures. *See, e.g., Antonelli v. Sheahan*, 81 F.3d 1422, 1430-31 (7th Cir. 1996) (any right to inmate grievance procedure is procedural rather than substantive right and thus state's inmate grievance procedures

do not give rise to liberty interest protected by due process clause); *Adams v. Rice*, 40 F.3d 72, 75 (4th Cir. 1994) (no constitutional right to participate in grievance procedures); *Flick v. Alba*, 932 F.2d 728, 729 (8th Cir. 1991) (same). The Fifth Circuit has held that "a prisoner has a liberty interest only in freedoms from restraint imposing *atypical* and significant hardship on the inmate in relation to the ordinary incidents of prison life." *Geiger v. Jowers*, 404 F.3d 371, 374 (5th Cir. 2005) (alterations and quotation marks omitted). A prisoner "does not have a federally protected liberty interest in having these grievances resolved to his satisfaction." *Id.*

To the extent Chandler challenges the adequacy of the prison grievance process, including the thoroughness of the investigation of his grievances or the lack of official response to them, those allegations will be dismissed for failure to state a claim upon which relief could be granted.

B. Statute of Limitations

"Because no specified federal statute of limitations exists for § 1983 suits, federal courts borrow the forum state's general or residual personal-injury limitations period, … which in Mississippi is three years." *Edmonds v. Oktibbeha Cty.*, 675 F.3d 911, 916 (5th Cir. 2012) (citing Miss. Code Ann. § 15-1-49). However, "[f]ederal law governs when a cause of action under § 1983 accrues." *Redburn v. City of Victoria*, 898 F.3d 486, 496 (5th Cir. 2018). Under federal law, "[t]he limitations period begins to run when the plaintiff becomes aware that he has suffered an injury or has sufficient information to know that he has been injured." *Id*. (quotation marks omitted). In this case, Chandler became aware of the level of his medical care at the time he received it or should have received it.

The Clerk of the Court docketed Chandler's original complaint on August 13, 2015; he signed it on August 11, 2015. Doc. #1 at 6. Under the prison mailbox rule, a prisoner's federal

complaint is deemed filed when he delivers the petition to prison officials for mailing to the district court. *Spotville v. Cain*, 149 F.3d 374, 376–78 (5th Cir. 1998) (relying on *Houston v. Lack*, 487 U.S. 266 (1988), and its progeny). The Court presumes Chandler delivered his complaint to prison officials on the date he signed it—August 11, 2015.[7] Thus, any claims arising before August 11, 2012—three years before Chandler signed his complaint—would fall outside the statute of limitations for a case filed under § 1983.[8] For this reason, Chandler's claims regarding his 2010 treatment for a bone spur in his left foot, as well as his 2011 tonsillectomy and associated after-care, must be dismissed as barred by Mississippi's three-year general statute of limitations.

C. Exhaustion

Congress enacted the Prison Litigation Reform Act ("PLRA"), 42 U.S.C. §1997e *et seq.*—including its requirement that inmates exhaust their administrative remedies before filing suit—in an effort to address the large number of prisoner complaints filed in federal courts. *Jones v. Bock*, 549 U.S. 199, 202 (2007). The exhaustion requirement is meant to distinguish frivolous claims from colorable ones, as "[p]risoner litigation continues to account for an outsized share of filings

[7] "It is generally contrary to the Prison Mailbox Rule to use a later date—such as the date the U.S. Postal Service postmarked the envelope or the date the Court Clerk's Office stamped the envelope 'received'—as an incarcerated *pro se* party's filing date." *Wolff v. California*, 235 F.Supp.3d 1127, 1129 n.1 (C.D. Cal. 2017). As there is no indication when Chandler delivered his complaint to prison officials, the Court will give Chandler the benefit of the doubt and use the earlier date on which he signed the complaint rather than the later date on which it was received by the Clerk of Court after it had been mailed from the prison.

[8] The continuing violation doctrine allows a plaintiff to defeat a statute of limitations defense. Under 42 U.S.C. § 1983, a continuous and ongoing constitutional violation tolls the statute of limitations period since "the staleness concern disappears." *McGregor v. La. State Univ. Bd. of Sup'rs*, 3 F.3d 850, 867 (5th Cir. 1993) (quoting *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 381 (1982)). The continuing violation doctrine—which is not raised by Chandler—does not apply in this case. First, Chandler frames his claims in terms of discrete events—the treatment of his tonsils and the treatment of his hip, foot, and back pain, among other ailments. *See* Doc. #24 at 4. Second, because a wide variety of medical professionals—both MDOC personnel and medical providers practicing outside of the prison—treated Chandler over the years, and he has not alleged that the providers, in concert, intentionally deprived him of adequate medical care. Thus, Chandler has not alleged a continuing violation, but a series of individual violations involving different defendants. Moreover, Chandler has not alleged that an MDOC policy exists which caused the alleged denial of medical care, as discussed below.

in federal district courts" and Congress sought to ensure "that the flood of nonmeritorious claims does not submerge and effectively preclude consideration of the allegations with merit." *Id*. at 203 (quotation marks omitted).

The PLRA's exhaustion requirement applies to actions filed under §1983. 42 U.S.C. §1997e(a). The exhaustion requirement protects administrative agency authority, promotes efficiency, and produces "a useful record for subsequent judicial consideration." *Woodford v. Ngo*, 548 U.S. 81, 89 (2006). A prisoner cannot satisfy the exhaustion requirement "by filing an untimely or otherwise procedurally defective administrative grievance or appeal [because] proper exhaustion of administrative remedies is necessary." *Id*. at 83–84; *see Johnson v. Ford*, 261 F. App'x 752, 755 (5th Cir. 2008) (Fifth Circuit takes "a strict approach" to PLRA's exhaustion requirement); *Lane v. Harris Cty. Med. Dep't*, 266 F. App'x 315, 2008 WL 116333, at *1 (5th Cir. 2008) (unpublished table decision) (under PLRA, "the prisoner must not only pursue all available avenues of relief; he must also comply with all administrative deadlines and procedural rules"). "[A] prisoner must … exhaust administrative remedies even where the relief sought—monetary damages—cannot be granted by the administrative process." *Woodford*, 548 U.S. at 85.

Exhaustion is mandatory and non-discretionary. *Gonzalez v. Seal*, 702 F.3d 785, 787 (5th Cir. 2012). "Whether a prisoner has exhausted administrative remedies is a mixed question of law and fact." *Dillon v. Rogers*, 596 F.3d 260, 266 (5th Cir. 2010). As "exhaustion is a threshold issue that courts must address to determine whether litigation is being conducted in the right forum at the right time, … judges may resolve factual disputes concerning exhaustion without the participation of a jury." *Id*. at 272. The United States Supreme Court has recognized the need for significant consequences where a prisoner deviates from the prison grievance procedural

rules:

> The benefits of exhaustion can be realized only if the prison grievance system is given a fair opportunity to consider the grievance. The prison grievance system will not have such an opportunity unless the grievance complies with the system's critical procedural rules. A prisoner who does not want to participate in the prison grievance system will have little incentive to comply with the system's procedural rules unless noncompliance carries a sanction ….

Woodford, 548 U.S. at 95.

MDOC, pursuant to Miss. Code Ann. § 47-5-801, has established a two-step Administrative Remedy Program ("ARP") through which prisoners may seek formal review of their complaints or grievances while incarcerated. *Threadgill v. Moore*, No. 3:10-cv-378, 2011 WL 4388832, at *3 & n.6 (S.D. Miss. July 25, 2011). Under the ARP, an inmate must make a "request to the [ARP] in writing within a 30 day period after an incident has occurred." *Inmate Handbook*, Miss. Dep't of Corrs. (June 2016), at ch. VIII(IV)(A).[9] The request is then screened to ensure it meets certain criteria. *Id*. at ch. VIII(V). If the request meets the specified criteria, it will be accepted into the ARP and proceeds to the first step. *Id*.

At the ARP's first step, a prison official responds to the request using a Form ARP-2. *Id*. at ch. IV. On this form, inmates can indicate whether they are dissatisfied with the outcome of the first step by "giv[ing] a reason for their dissatisfaction with the previous response." *Id*. An inmate who timely indicates that he is dissatisfied with the first step of the ARP process proceeds to the second step. *Id*. In the second step, like the first step, a prison official responds to the ARP request. *Id*. If the inmate remains unsatisfied with the result, he may then file a lawsuit.

[9] Available at: http://www.mdoc.ms.gov/Inmate-Info/Documents/CHAPTER_VIII.pdf. The Court takes judicial notice of MDOC's Inmate Handbook. *See* Fed. R. Evid. 201(b)(2) ("The court may judicially notice a fact that is not subject to reasonable dispute because it ... can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned."); *see, e.g., Smith v. Polk Cty.*, No. 805-cv-884-24, 2005 WL 1309910, at *3 (M.D. Fla. May 31, 2005) (judicial notice taken of inmate handbook and grievance procedures stated therein).

Id.

It is impossible for Chandler to have exhausted his allegations arising after the filing of this case. Thus, his claims regarding improper after-care following his second, August 31, 2015, tonsillectomy as well as the July 21, 2016, incident in which he alleges he was forced to carry seventy-five pounds, will be dismissed without prejudice for failure to exhaust administrative remedies.[10]

D. Sovereign Immunity

Chandler has sued all defendants in both their official and individual capacities. Doc. #24 at 24. The Eleventh Amendment protects a state's sovereign immunity from suit and liability on both federal and state causes of action in any federal court. *Meyers ex rel. Benzing v. Texas*, 410 F.3d 236, 252–53 (5th Cir. 2005). An assertion of Eleventh Amendment immunity must be addressed before the merits of a complaint. *United States v. Tex. Tech Univ.*, 171 F.3d 279, 286 (5th Cir. 1999). However, whether a "particular statutory cause of action … itself permits,"[11] the action to be asserted against a state should be considered before "inquiring into any Eleventh Amendment immunity."[12]

"[A] State is not a person within the meaning of § 1983." *Will v. Mich. Dep't of State*

[10] Though an earlier grievance regarding an ongoing policy or practice may obviate the need for filing later grievances as to the same issue, that is not the situation in the present case. Where a § 1983 plaintiff's complaint addresses an ongoing problem or multiple instances of the same type of harm—arising out of a prison policy—he need not file a new grievance in each new instance to quality for exhaustion. "Where the original grievance complains of a general prison policy, changed circumstances will not necessarily necessitate re-exhaustion." *Moussazadeh v. Tex. Dep't of Criminal Justice*, 703 F.3d 781, 788 (5th Cir. 2012), *as corrected* (Feb. 20, 2013). In his complaint, Chandler has not claimed that an MDOC policy gave rise to the denial of medical care he has alleged. In addition, Chandler's non-medical care claims clearly arose after the filing of his complaint.

[11] *Vt. Agency of Nat. Res. v. United States ex rel. Stevens*, 529 U.S. 765, 779 (2000).

[12] *United States ex rel. Adrian v. Regents of Univ. of Cal.*, 363 F.3d 398, 402 n.3 (5th Cir. 2004) (citing *Stevens*, 529 U.S. at 779–80).

Police, 491 U.S. 58, 64 (1989). This holding also applies to any "governmental entities that are considered 'arms of the State' for Eleventh Amendment purposes." *Id*. at 70. The State, arms of the State, and state officials sued in their official capacity are not "persons" within the meaning of § 1983. *Id*. at 70–71. Accordingly, MDOC, and its officials Fisher, Lee, Williams, and Perry—in their official capacities—are entitled to dismissal.

E. Denial of Adequate Medical Care

As discussed above, Chandler's claims of denial of adequate medical care occurring in 2010 and 2011 outside the statute of limitations—or after the filing of this case in 2015—cannot be considered under § 1983. However, even if the Court considered all of Chandler's medical care allegations—from 2009 (the year of the first entry in his medical record regarding his complaints) to present—his allegations fail to state a claim upon which relief could be granted.

1. Deliberate Indifference Standard

Chandler claims the defendants denied him adequate medical care and treatment for his back, chest, foot, and hip pain, as well as the repeated infections of his right tonsil. To prevail on an Eighth Amendment claim for denial of medical care, Chandler must allege facts which demonstrate "deliberate indifference to [his] serious medical needs [that] constitutes the unnecessary and wanton infliction of pain … whether the indifference is manifested by prison doctors … or by prison guards in intentionally denying or delaying access to medical care …." *Estelle v. Gamble*, 429 U.S. 97, 104–105 (1976) (quotation marks omitted); *see Mayweather v. Foti*, 958 F.2d 91, 91 (5th Cir. 1992) (inadequate medical care claim requires proof of "deliberate indifference to serious medical needs"). The test for establishing deliberate indifference is one of "subjective recklessness as used in the criminal law." *Farmer v. Brennan*, 511 U.S. 825, 839

(1994). Under this standard, a state actor may not be held liable under § 1983 unless a plaintiff alleges facts which, if true, would establish that the official "knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and [the official] must also draw the inference." *Id*. at 837. Only in exceptional circumstances may a court infer knowledge of substantial risk of serious harm by its obviousness. *Id*. at 842–43. Negligent conduct by prison officials does not rise to the level of a constitutional violation. *Daniels v. Williams*, 474 U.S. 327, 328–29 (1986).

In cases, such as this, which allege delayed medical attention rather than its outright denial, a plaintiff must demonstrate that he suffered substantial harm resulting from the delay to state a claim for a civil rights violation. *Mendoza v. Lynaugh*, 989 F.2d 191, 195 (5th Cir. 1993). A prisoner's mere disagreement with medical treatment provided by prison officials does not state a claim against the prison for deliberate indifference to serious medical needs. *Gibbs v. Grimmette*, 254 F.3d 545, 549 (5th Cir. 2001).

"Deliberate indifference is not established when medical records indicate that the plaintiff was afforded extensive medical care by prison officials." *Brauner v. Coody*, 793 F.3d 493, 500 (5th Cir. 2015) (quotation marks and alterations omitted). Nor is it established when a physician does not accommodate either a prisoner's requests or a prisoner's disagreement with the treatment. *Id*.; *Miller v. Wayback House*, 253 F. App'x 399, 401 (5th Cir. 2007). To meet his burden in establishing deliberate indifference on the part of medical staff, Chandler "must show that [medical staff] refused to treat him, ignored his complaints, intentionally treated him incorrectly, or engaged in any similar conduct that would clearly evince a wanton disregard for any serious medical needs."

Brauner, 793 F.3d at 498.

2. Application to Facts

The Court has reviewed the extensive, nearly 700-page record of Chandler's medical treatments for his various conditions and summarized those pertaining to the issues in this case in chronological order by type of ailment. *See* Ex. A. The summary includes all treatment Chandler received in the years before and after his filing of this case to provide a complete picture of the level of treatment. While Chandler was treated for conditions other than those at issue here, they are not reflected in the summary as his claims do not involve them.

Chandler was treated one hundred and six times for SI Joint Dysfunction, five times for plantar fasciitis (which medical personnel came to believe was related to his SI Joint Dysfunction), one hundred and fifteen times for tonsil ailments (including two surgeries to remove his tonsils), seventeen times for costochondritis, and five times for shoulder pain (which doctors believed could be related to costochondritis). *See generally id*. Thus, Chandler was examined or treated two hundred and forty-eight times from 2009 to 2018—twenty-eight times per year on average—for the conditions relevant to his complaint.

Early in the treatment of his various maladies, Chandler requested more aggressive treatment and referral to a specialist. *Id*. at 2. However, in most cases, medical personnel chose to initially provide more conservative treatment, moving toward more aggressive treatment when the conservative treatment failed to provide satisfactory results.[13] Medical providers also prescribed medications—nonsteroidal anti-inflammatory drugs ("NSAIDs"), injections, and various cough

[13] For example, as to Chandler's tonsil trouble, medical personnel first prescribed a special mouthwash and gargling with warm salty water; later, they prescribed antibiotics, and then changed to a different antibiotic when the previous one did not work. Ex. A at 3.

and cold medications—to relieve the painful symptoms of Chandler's recurring tonsil infections. *Id*. at 1. They further conducted diagnostic testing, such as analyzing cultures of his tonsil drainage. *Id*. at 3. When his sinus symptoms persisted, despite the escalating treatments, medical personnel referred Chandler to an off-site ear, nose, and throat surgeon ("ENT"), and his tonsils were removed in 2011. *Id*.

Eventually, Chandler's tonsil trouble returned, and medical personnel followed the same escalating protocol as before, culminating in a second tonsillectomy in 2015 which removed a "tonsil stump." *Id*. at 4. Chandler's throat problems recurred, even after the second surgery, and the providers then conducted diagnostic testing, provided Chandler instructions on oral hygiene, and prescribed him NSAIDs and antibiotics. *Id*. When those treatments did not provide relief, he was again referred to an off-site ENT and, according to his statement to medical personnel, on January 10, 2018, was recommended for a third tonsil surgery. *Id*. On the latest entry in his medical records regarding his tonsils entered on March 9, 2018, Chandler was directed to continue his medication. *Id*.

Chandler complains about the treatment he received after his tonsil surgery on February 23, 2011—specifically, he alleges MDOC personnel failed to provide him with a special diet and cool environment, which he believes led to an infection at the surgery site. *Id.* at 3; Doc. #24 at 7. Medical records show that Chandler suffered bleeding and an infection in early March of 2011, less than two weeks after surgery, and medical personnel prescribed Chandler antibiotics. Ex. A at 3. Chandler's next examination regarding tonsil trouble occurred over two years later on September 27, 2013. *Id*.

Chandler also claims that in 2015, he developed a bacterial infection in his right tonsil and

the defendants delayed treating the condition for five months. Doc. #24 at 11. However, Chandler's medical records show that he was examined and treated multiple times between March 31, 2015, and his surgery on August 28, 2015. Ex. A at 3–4. On March 31, 2015, medical personnel prescribed gargling with warm salt water and medication. *Id*. at 3. Medical personnel also educated Chandler on how to manage his tonsil condition. *Id*. Chandler then visited the doctor two weeks later, who referred him to an ENT. *Id*. Chandler returned to the clinic on April 24, 2015, and his tonsil appeared normal. *Id*. at 4. On May 11, 2015, Chandler returned to the prison clinic for a follow-up examination. *Id*. He did not show up for his next appointment on June 24, 2015. *Id*. During an examination on June 29, 2015, medical personnel noted a swollen lymph node and referred Chandler to a surgeon. *Id*. Chandler visited the surgeon on August 18, 2015, and the surgeon examined him and determined surgery would be appropriate. *Id*. Chandler was transported to the hospital on August 27, 2015, where doctors performed a pre-surgery examination and the next day, he underwent surgery to remove the remnants of his right tonsil. *Id*.

The same pattern—medical personnel escalating treatment with the worsening of Chandler's symptoms—also holds true for his complaints regarding SI Joint Dysfunction. It took time for medical providers to determine the cause of Chandler's back, hip, and foot pain, as it was initially diagnosed separately as sciatica[14] and plantar fasciitis. *Id*. at 1–2. Chandler's medical providers subsequently determined that it was likely that all or most of his symptoms related to his back, hip, and foot arose from SI Joint Dysfunction and bone spurs, and he was treated for those

[14] Sciatica is "[p]ain in the lower back and hip radiating down the back of the thigh into the leg, initially attributed to sciatic nerve dysfunction … but now known to usually be due to herniated lumbar disk compressing a nerve root …." STEDMAN'S MEDICAL DICTIONARY 801240 (2014).

conditions. *Id*. at 1–2. During treatment for his SI Joint Dysfunction symptoms, medical personnel provided Chandler with diagnostic testing (including x-rays and magnetic resonance imaging), NSAIDS, injections, physical therapy, a cane, an SI belt, and other treatments. *Id*. at 1–2. Medical providers also gave Chandler instructions regarding proper posture and exercises to relieve symptoms. *Id*. These treatments provided Chandler partial—but not complete—relief.

Chandler also contends that medical personnel misdiagnosed his chest pain as a symptom of costochondritis. *See* Doc. #58-4 at 50. When Chandler experienced chest pain, he wanted to ensure that the symptoms were, in fact, costochondritis—and not heart disease. *See id*. at 45. Medical personnel provided Chandler with antibiotics (when it seemed the chest pain was due to a cough), ibuprofen, Indomethacin,[15] acetaminophen, injections, prednisone,[16] Ketorolac,[17] and Mobic. Ex. A at 4. These treatments appear to have worked for a time but the pain returned, and medical personnel reassured Chandler that his chest pains were not due to heart disease. Doc. #58-4 at 45; *see* Ex. A at 4. Chandler is, nevertheless, skeptical of the diagnosis.

Chandler's shoulder pain was diagnosed as Tenosynovitis,[18] although some providers believed it was related to costochondritis. Ex. A at 5; Doc. #58-2 at 95. For his shoulder pain, medical providers followed a course of treatment like that for costochondritis—NSAIDs and pain medication. Ex. A. at 5.

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[15] Indomethacin is a "potent analgesic, antipyretic, and nonsteroidal antiinflammatory agent used to treat acute exacerbations of various joint diseases. It is also used to produce closure of a patent ductus arteriosus in infants." *Id*. at 442720.

[16] Prednisone is a "dehydrogenated analogue of cortisone with the same actions and uses; must be converted to prednisolone before active; inhibits proliferation of lymphocytes." *Id*. at 717600.

[17] Ketorolac is an NSAID. *Id*. at 267230.

[18] Tenosynovitis is defined as the "[i]nflammation of a tendon and its enveloping sheath." *Id*. at 902170.

Over his nine years of incarceration with the MDOC, Chandler has been treated by medical personnel on hundreds of occasions. In addition to providing Chandler with a great deal of medical treatment for his ailments, prison medical personnel have ordered two surgeries to remove his tonsils.

"Deliberate indifference is not established when medical records indicate that [the prisoner] was afforded extensive medical care by prison officials." *Brauner*, 793 F.3d at 500 (quotation marks omitted). By any measure, Chandler was afforded extensive medical care by prison officials. Chandler's desire for more aggressive medical treatments to be administered sooner is merely a claim that physicians did not accommodate his requests in the manner he desired—which does not rise to the level of a constitutional violation. *Id.*; *Miller*, 253 F. App'x at 401. Based on the summary judgment record, Chandler has not shown that medical staff "refused to treat him, ignored his complaints, intentionally treated him incorrectly, or engaged in any similar conduct that would clearly evince a wanton disregard for any serious medical needs." *Brauner*, 793 F.3d at 498. Rather, the summary judgment record reflects that Chandler was provided with escalating care for his conditions—including surgery for his tonsils—until his complaints were resolved. Accordingly, Chandler's denial of adequate medical assistance claim is without merit and will be dismissed.

IV
Conclusion

The defendants' motion for summary judgment [45] is **GRANTED**. Accordingly:

1. Chandler's allegations for failure to adequately respond to grievances and denial of adequate medical care are **DISMISSED** for failure to state a claim upon which relief can be granted;

2. MDOC, Marshall Fisher, Earnest Lee, Jerry Williams, and Gloria Perry, in their official capacities, are **DISMISSED with prejudice**;

3. Chandler's claims regarding events occurring before August 11, 2012, are **DISMISSED with prejudice** as barred by the applicable statute of limitations; and

4. Chandler's allegations regarding events occurring after the filing of this case (including the stomping of his hand and the forced carrying of a heavy load) are **DISMISSED** for failure to exhaust administrative remedies.

SO ORDERED, this 28th day of September, 2018.

/s/Debra M. Brown
UNITED STATES DISTRICT JUDGE

EXHIBIT A

Joey Montrell Chandler, 4:15-CV-102

Medical Treatment Relevant to Complaint (Excluding Routine Treatment or Treatment for Other Conditions)

Number of Times Treated:

SI Joint Dysfunction:	**106**
Plantar fasciitis (later determined to be SI Joint Dysfunction):	**5**
Tonsils:	**115**
Costochondritis:	**17**
Shoulder pain (later found to be Costochondritis:	**5**
Total number of times treated (all relevant medical issues):	**248** (roughly 28 times per year)

Relevant Medical Treatment

SI Joint (Back, foot, hip pain)

Date of Treatment	Reference	Type of Visit	Treatment, comments
9/13/2010	58-2 at 1	Exam	Apply warm compress to hip
11/7/2010	58-3 at 109	Exam	MD notified; cool compresses, moist heat, avoid sports, then strength exercises
12/3/2010	58-2 at 52	Exam	Order spine x-ray; no lifting
12/9/2010	58-6 at 46	X-ray results	Minor degenerative disc disease, L5-S1; no regional bony fracture or dislocation
7/12/2011	58-3 at 101	Exam	Refer to MD; meds per protocol, IBU
7/15/2011	58-2 at 72	Exam	Left back/foot pain: Foot X-ray
8/12/2011	58-2 at 70	Follow-up	X-ray findings, foot and back painNaproxen
8/23/2011	58-3 at 99	Exam	Refer to MD; arch painful, x-ray normal, meds do not work
8/26/2011	58-2 at 68	Exam	Back pain: Crutches, heat, prednisone, lower bunk profile, no weight bearing, injection, f/u 2 weeks
9/2/2011	58-3 at 97	Exam	Showed pt how to adjust crutches
9/6/2011	58-3 at 66	Exam	Showed pt how to adjust crutches
9/20/2011	58-2 at 66	Exam	Left back/foot pain: IBU
9/22/2011	58-6 at 40	Exam	Refused treatment
2/17/2012	58-3 at 91	Exam	IBU, refer to MD
2/21/2012	58-2 at 63	Exam	IBU
4/12/2012	58-2 at 110	Follow-up	Prescribed Medrol, APAP, alternate APAP and NSAIDS
7/3/2012	58-2 at 108	Exam	Refill of APAP
7/18/2012	58-2 at 106	Follow-up	Lower bunk profile, IBU, education
1/30/2013	58-4 at 10	Exam	Meds given per protocol, f/u scheduled
4/15/2013	58-2 at 101	Follow-up	IBU
4/15/2013	58-6 at 80	Exam	Continue taking IBU -- with food
4/29/2013	58-2 at 14	Exam	Change meds, IBU to APAP, teach proper back mechanics
6/7/2013	58-4 at 8	Exam	APAP given; continue current medication regimen
6/11/2013	58-2 at 100	Follow-up	Diagnosis: Sciatica
8/2/2013	58-1 at 66	Return from Spinal MRI	No progress of disease
8/2/2013	58-6 at 52	MRI results: Spine	Unremarkable noncontrast lumbar spine MRI
8/10/2013	58-4 at 4	Exam	IBU given, patient assured, appt pending with MD
8/15/2013	58-4 at 6	Exam	Referred to MD, pain meds offered but refused, scheduled MRI
9/5/2013	58-2 at 12	Follow-up	Results from MRI, APAP Tabs,
9/13/2013	58-3 at 21	Physical therapy (PT)	
9/17/2013	58-5 at 84	Exam	Received walking cane
10/17/2013	58-4 at 2	Exam	Refer to provider; meds per protocol, pt educated
4/11/2014	58-4 at 24	Exam	Refer to provider
4/18/2014	58-2 at 10	Exam	Analgesics, labs
6/18/2014	58-2 at 48	Follow-up	
6/19/2014	58-1 at 44	Exam	Referral to PT
9/30/2014	58-1 at 2	Exam	
9/30/2014	58-2 at 81	Exam	Sciatic nerve pain: SI joint x-ray (rule out sacroilitis, other pathology)
10/1/2014	58-2 at 44	Follow-up	SI joint pain: PT, advised to walk w/o cane
10/1/2014	58-5 at 91	Exam	Received Meloxicam
10/2/2014	58-6 at 48	X-ray results: SI joint	SI joints within normal limits
10/7/2014	58-1 at 3	Exam	Appt scheduled
10/9/2014	58-1 at 43	Exam	Wants PT
10/9/2014	58-2 at 43	Follow-up	SI joint pain: Walking w/o cane, but pain moved to left side, send to PT
10/22/2014	58-3 at 20	Physical therapy (PT)	
11/5/2014	58-3 at 18	Physical therapy (PT)	
11/10/2014	58-3 at 17	Physical therapy (PT)	
11/17/2014	58-1 at 42	Physical therapy (PT)	

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11/17/2014	58-2 at 79	Exam	Right hip pain: Mobic
11/17/2014	58-3 at 15	Physical therapy (PT)	
11/17/2014	58-5 at 89	Exam	Received bottom bunk profile
11/19/2014	58-6 at 3	Exam	Received Meloxicam
12/1/2014	58-3 at 13	Physical therapy (PT)	
12/8/2014	58-3 at 11	Physical therapy (PT)	
12/17/2014	58-1 at 5	Appt scheduled	
12/17/2014	58-4 at 19	Exam	Follow-up with MD pending
12/18/2014	58-2 at 41	Follow-up	Hip and foot pain: Insisted on CT scan; left office when request was denied. Dr. will examine when pt returns.
2/20/2015	58-4 at 43	Exam	Refer to MD
3/9/2015	58-6 at 6	Exam	Received Prednisone, IBU (keep on person)
5/4/2015	58-1 at 11	Follow-up	
5/4/2015	58-4 at 38	Exam	Pt education, refer to MD, avoid sports
5/5/2015	58-3 at 123	Exam	Prescribe Prednisone, Mobic; previously tried PT
5/6/2015	58-6 at 7	Exam	Received Prednisone, Mobic (keep on person)
5/14/2015	58-2 at 125	Exam	Inform pt to finish prednisone pack (on day 5 of 12)
7/14/2015	58-6 at 8	Exam	Received Meloxicam (keep on person)
7/29/2015	58-1 at 15	Follow-up	
7/29/2015	58-4 at 34	Exam	Follow-up with MD
8/13/2015	58-2 at 122	Exam	Prescribed Mobic
10/15/2015	58-1 at 16	Follow-up	
10/15/2015	58-4 at 30	Exam	Cold compress, elevate leg, Acetaminophen, Ibuprofen, crutches, lay-in, refer to MD
3/17/2016	58-4 at 67	Exam	Refer to provider for f/u
3/18/2016	58-2 at 120	Exam	Prescribed rubber tennis shoes; no indication for bottom bunk
6/8/2016	58-4 at 65	Exam	Checking on shoes
6/10/2016	58-2 at 118	Exam	Renew bottom bunk profile
6/12/2016	58-6 at 58	Exam	Ordered orthopedic shoes
8/14/2016	58-1 at 23	Exam	
8/14/2016	58-4 at 56	Exam	Requests MRI, ortho shoes, meds ineffective. Referral to MD for MRI and shoe request
9/7/2016	58-1 at 24	Exam	Wants orthopedic shoes
9/7/2016	58-1 at 40	Exam	Refer to PT for ortho shoes
9/7/2016	58-4 at 54	Exam	Request orthopedice shoes; referred to PT for shoes
9/13/2016	58-3 at 10	No show	Reschedule due to transporation problem
9/17/2016	58-1 at 25	Exam	Wants orthopedic shoes, treatment by specialist, referral to specialist
9/17/2016	58-4 at 52	Exam	Pt says Tylenol not working; refer to provider; return to clinic with any complications
9/20/2016	58-3 at 8	Physical therapy (PT)	
9/27/2016	58-3 at 7	Physical therapy (PT)	
10/4/2016	58-3 at 33	Physical therapy (PT)	
10/5/2016	58-2 at 32	Follow-up: back pain and shoes	DM shoes not indicated
10/11/2016	58-3 at 32	Physical therapy (PT)	
10/11/2016	58-6 at 14	Exam	Received orthopedic shoes
10/12/2016	58-6 at 87	Exam	Pt received orthopedic shoes
10/18/2016	58-3 at 30	Physical therapy (PT)	
10/25/2016	58-3 at 29	Physical therapy (PT)	No-show, transporation problem
11/8/2016	58-3 at 27	Physical therapy (PT)	
11/15/2016	58-3 at 25	Physical therapy (PT)	
1/11/2017	58-6 at 17	Exam	Received SI belt
1/12/2017	58-3 at 23	Physical therapy (PT)	
3/30/2017	58-4 at 47	Exam	Renew bottom rack; appt scheduled with provider
3/31/2017	58-2 at 112	Exam	First diagnosis of SI dysfunction; prescribe Acetaminophen
3/31/2017	58-6 at 18	Exam	Received bottom bunk profile
7/12/2017	58-6 at 77	Exam	Educate pt regarding disease process; lifestyle modification
11/21/2017	58-1 at 29	Exam, referral	Wants orthopedic shoes
11/21/2017	58-1 at 35	Exam	Refer to PT for ortho shoes. Dr.: "Shoes are supposed to last three years."
11/21/2017	58-1 at 57	Exam	Received orthopedic shoes
11/21/2017	58-6 at 57	Exam	Ordered orthopedic shoes
11/29/2017	58-1 at 82	Receipt of orthopedic shoes	
11/29/2017	58-6 at 19	Exam	Received diabetic shoes, 1 year
3/9/2018	58-1 at 31	Exam	Received bottom bunk profile

Plantar fasciatis (foot pain) -- later determined to be related to SI Joint Dysfunction

11/15/2011	58-3 at 95	Exam	Refer to MD
11/23/2011	58-1 at 83	Exam	Medication applied
2/19/2015	58-1 at 6	Exam	
3/5/2015	58-3 at 4	Exam	Prednisone, IBU, 1 year bottom bunk profile, review nutrition, exercise, medication
3/6/2015	58-1 at 7	Exam	

Tonsils

4/21/2009	58-3 at 36	Exam	Prescribed Miracle Mouthwash
8/5/2009	58-3 at 40	Exam	Prescribed Guaifenesin, Mycostatin
8/14/2009	58-3 at 38	Exam	Prescribed Erythromycin, Miracle Mouthwash

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3/3/2010	58-3 at 83	Exam	Forward Sick Call Request to MD for eval and medication
3/3/2010	58-4 at 76	Exam	Rocephin injection
3/10/2010	58-3 at 79	Exam	OTC medication given, return to clinic for MD evaluation
3/17/2010	58-2 at 58	Exam	Penicillin
3/17/2010	58-3 at 81	Exam	Referral to MD
4/10/2010	58-3 at 62	Exam	OTC medication, spec. consult pending; gave Chlorpheniramine Maleate for congestion
4/12/2010	58-2 at 7	Exam	Refer to ENT: Prior treatments ineffective
4/22/2010	58-6 at 28	Exam	Blood drawn for lab work
5/5/2010	58-2 at 6	Exam	ENT consult: Throat culture
5/13/2010	58-2 at 5	Follow-up	Enlarged tonsils: Salt water gargles after food
7/23/2010	58-3 at 75	Exam	Referral to MD, appt scheduled
7/28/2010	58-2 at 56	Exam	Keflex
8/11/2010	58-3 at 73	Exam	Doctor evaluation, appt scheduled
8/13/2010	58-2 at 54	Exam	Solu-Medrol, 1 dose; prednisone
9/7/2010	58-3 at 71	Exam	Referral to provider, antibiotic did not work
9/9/2010	58-6 at 27	Exam	Received Bicillen injection
9/10/2010	58-3 at 68	Exam	Bicillin injection
9/12/2010	58-6 at 26	Exam	Received Bicillen injection
9/13/2010	58-2 at 1	Follow-up after 5 days bicillin injections	Tonsil infection
9/13/2010	58-6 at 25	Exam	Received Bicillen injection
9/24/2010	58-3 at 69	Exam	Referral to provider
9/29/2010	58-1 at 88	Follow-up after antibiotics	No acute infection, no swelling
10/5/2010	58-3 at 115	Exam	Refer to provider; Chlorpheneiramine maleate, Guaifenesin
10/6/2010	58-3 at 111	Exam	Meds (APAP) given. Did not receive mouthwash; tonsils sore; lymph node swelling; mild tonsil swelling
10/12/2010	58-5 at 74	Exam	Pt refused treatment
10/12/2010	58-6 at 22	Exam	Pt referred to MD for treatment
10/15/2010	58-3 at 113	Exam	Schedule provider eval
10/19/2010	58-2 at 28	Exam	Tonsils enlarged, wants tonsils removed
10/26/2010	58-6 at 73	Exam	Prescribed Cepacol lozenges
11/2/2010	58-2 at 26	Exam	IBU prescribed, numerous courses of PCN, Keflex, amoxicillin failed. Culture taken
11/5/2010	58-3 at 44	Exam	Prescribed Ciprofoxacin
11/16/2010	58-2 at 24	Exam	Infection noted, prescribed Cipro
12/10/2010	58-2 at 21	Exam	Cepacol lozenges
12/15/2010	58-2 at 20	Follow-up re: sore throat	Left doctor, refused advice. No active infection.
12/17/2010	58-1 at 45	Exam, referal to OMC	
12/28/2010	58-2 at 19	Follow-up re: tonsils bleeding	Awaiting ENT appt date
1/27/2011	58-1 at 63	Keflex, lortab off-site Dr. Visit	MD would like to remove tonsils
1/27/2011	58-6 at 69	Exam	Diagnosis of chronic adenotonsillitis; surgery recommended
2/7/2011	58-3 at 105	Exam	IBU, ctm; refer to MD; return to clinic if needed
2/22/2011	58-6 at 20	Pre-surgery Exam	Do not eat or drink anything after midnight
2/23/2011	58-3 at 43	Exam	Prescribed Keflex, Lortab, Liquid diet, move to CMCF Infirmary overnight
2/23/2011	58-6 at 45	Post-surgery observation	Throat pain; given Lortab
2/23/2011	58-6 at 50	Discharge summary: tonsillectomy	
2/23/2011	58-6 at 74	Exam	Prescribed Keflex, Lortab
2/24/2011	58-3 at 42	Exam	Prescribed Keflex, Lortab
2/24/2011	58-5 at 77	Exam	Full liquid diet
2/25/2011	58-6 at 44	Post-surgery observation	Resting quietly
3/2/2011	58-3 at 59	Exam	Prescribed warm water salt gargle, 2 weeks of soft diet
3/2/2011	58-3 at 103	Post-surgery exam	Spitting up blood; refer to MD
3/2/2011	58-5 at 78	Exam	Chewing problems diet, 2 weeks
3/8/2011	58-2 at 17	Follow-up	Tonsils removed: Infection noted; Prescribed Z-pack
9/27/2013	58-4 at 69	Exam	Toradol injection
12/9/2013	58-4 at 87	Exam	Toradol, Decadron injection
1/31/2014	58-3 at 54	Exam	Replaced Indomethacin with Tylenol E.S.
6/18/2014	58-6 at 81	Exam	Pt complained re: thryroid problem, stated x-rays were taken; none exist; malingering, mental disorder?
9/30/2014	58-6 at 82	Exam	Follow-up with Dr. Levine
3/24/2015	58-1 at 8	No show	Rescheduled, lockdown
3/24/2015	58-4 at 42	Exam	
3/31/2015	58-1 at 9	Exam	
3/31/2015	58-2 at 40	Follow-up	Instructed to gargle as needed
3/31/2015	58-4 at 40	Exam	Warm salt gargle, medication, patient education
4/14/2015	58-1 at 10	Exam	
4/14/2015	58-4 at 92	Exam	Pt wants referral to ENT; refer to MD
4/15/2015	58-1 at 41	Exam	Request ENT treatment
4/15/2015	58-2 at 39	Exam	Referral to ENT
4/24/2015	58-3 at 3	Exam	Tonsils look normal
5/11/2015	58-1 at 12	Follow-up	
5/11/2015	58-4 at 36	Exam	GI disruption from tonsils: Follow-up as needed
6/24/2015	58-1 at 13	No show	
6/29/2015	58-1 at 14	Exam	Lymph node swollen
6/29/2015	58-2 at 124	Exam	Refer to surgeon for consult
8/18/2015	58-1 at 68	Return from off-site visit	MD would like to remove "tonsil stumps"
8/18/2015	58-6 at 70	Pre-surgery exam	Free world provider
8/27/2015	58-3 at 53	Pre-surgery	NPO (nothing by mouth) after midnight

8/28/2015	58-1 at 69	Post-op discharge papers	
8/28/2015	58-1 at 73	Exam, return from off-site visit	No complaints
8/28/2015	58-3 at 35	Pathology	Tissue from oral surgery
8/28/2015	58-3 at 52	Post-surgery treatment	Prescribed Tylenol/Codeine
8/28/2015	58-3 at 60	Surgery	Removal of right tonsil
8/28/2015	58-6 at 49	Outpatient surgery orders	
8/28/2015	58-6 at 51	Surgical instruction sheet	
9/8/2015	58-2 at 37	Post-op follow-up: tonsils swelling, bleeding	Occasional bleeding, no swelling
9/15/2015	58-1 at 75	Exam, return from off-site visit	No complaints
10/8/2015	58-4 at 32	Exam	Refer to provider; f/u as needed
10/15/2015	58-1 at 16	Follow-up	
10/16/2015	58-3 at 51	Exam	Mild oral thrush; prescr Diflucan, Amox; ordered CBC, C-reactive protein test, Urinalysis
10/17/2015	58-2 at 121	Follow-up	Prescribed Amoxicillin, Diflucan, discussed oral hygiene
2/22/2016	58-4 at 28	Exam	Acetaminophen; return to clinic if symptoms continue
2/24/2016	58-1 at 18	Exam	
2/26/2016	58-3 at 50	Exam	Ordered lab test of right tonsil drainage
2/26/2016	58-4 at 26	Exam	Throat culture; antibiotic therapy; refer to provider for results; return to clinic as needed
3/5/2016	58-6 at 86	Exam	Follow-up with provider re: lab results
3/22/2016	58-1 at 17	No show	School
4/8/2016	58-6 at 10	Exam	Refused treatment (medication cleared up mouth drainage)
4/8/2016	58-6 at 30	Exam	Refused treatment
4/18/2016	58-1 at 19	Refused appointment	
6/8/2016	58-1 at 20	Follow-up	
6/8/2016	58-4 at 65	Exam	
7/7/2016	58-1 at 21	Exam	
7/7/2016	58-2 at 34	Follow-up	Z-pack
7/7/2016	58-4 at 63	Exam	Patient instructed per nursing protocol; referral to provider
7/22/2016	58-1 at 22	Exam	
7/22/2016	58-4 at 61	Exam	Return to clinic with any complications
8/14/2016	58-1 at 23	Exam	
8/17/2016	58-2 at 116	Exam	Prescribed Tylenol
12/1/2016	58-2 at 115	No-show	Rescheduled, transportation issue
2/3/2017	58-4 at 48	Exam	Refer to MD, insufficient light to see tonsil
2/9/2017	58-2 at 114	Exam	Wants ENT consult; tonsillectomy 2011 and 2015; refer to ENT
3/9/2017	58-1 at 61	Exam	Taught medication usage, comfort measures
10/2/2017	58-1 at 52	Exam	Wants update on ENT appt
11/21/2017	58-1 at 29	Exam	Refer to MD
1/10/2018	58-1 at 33	Exam	Check on surgery date
3/9/2018	58-1 at 31	Exam	Continue meds

Costochondritis (Chest, shoulder pain)

3/29/2012	58-2 at 61	Exam	Chest pain: Amoxicillin (for cough)
4/11/2012	58-3 at 89	Exam	IBU, refer to MD
8/17/2012	58-2 at 104	Exam	Chest pain: IBU, Indomethacin
9/27/2013	58-3 at 64	Exam	Chest pain: Notified Dr.
10/17/2013	58-4 at 2	Exam	Pt educated; refer to provider; meds per protocol; Acetaminophen
11/8/2013	58-3 at 123	Exam	Pt reassured; refer to MD; continue current medication
12/4/2013	58-3 at 121	Exam	Pt educated; refer to provider
12/27/2013	58-4 at 94	Exam	Prescribed Indocin
2/24/2014	58-3 at 117	Exam	Pt reassured; refer to MD
2/27/2014	58-2 at 90	Exam	Chest pain: Solu-Medrol injection
4/11/2014	58-4 at 24	Exam	Refer to provider
4/18/2014	58-2 at 10	Exam	No objective signs of costochondritis
11/24/2016	58-1 at 26	Follow-up	Burning, pain; diagnosed as costochondritis
11/24/2016	58-4 at 50	Exam	Refer to MD; Pt does not believe costochondritis diagnosis
12/5/2016	58-2 at 49	Follow-up	
4/23/2017	58-1 at 84-87	Exam	Chest pain, left arm numbness, prescr prednisone, Ketorolac
4/26/2017	58-1 at 47	Exam	Chest pain, left arm pain
5/26/2017	58-4 at 45	Exam	Pt reassured, refer to provider

Shoulder Pain (Suspected Costochondritis)

10/21/2013	58-2 at 98	Follow-up	Diagnosis: Tenosynovitis; gave injection; changed medication to APAP
11/21/2013	58-2 at 97	Follow-up	Changed medication to naproxen
12/9/2013	58-2 at 96	Follow-up	Changed medication from IBU to Mobic
12/23/2013	58-2 at 94	Follow-up	Changed medication from IBU and Mobic to Indocin
12/24/2013	58-3 at 119	Exam	Refer to MD; continue current pain meds