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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9014
Chester Mental Health Center
July 15, 2008

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility, which is the most-restrictive mental health center in the state, provides services for approximately 300 male residents. The specific allegations are as follows:

1. Staff at Chester Mental Health Center confiscated a recipient's Bible.
2. The door to a recipient's room was locked during the day preventing him from entering the room.
3. The recipient did not have water in his room and in his bathroom stool.
4. The recipient had a broken clavicle (collarbone) that was not treated.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/102, 405 ILCS 5/2-104, 405 ILCS 5/2-112 and 405 ILCS 5/2-201) and the Illinois Administrative Code (Adm. Code) (59 Ill. Adm. Code 112.30). Sections 5/1-101.2 and 5/1-117.1 of the Code are pertinent to the allegations.

Section 5/2-102 of the Code states, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan."

Section 5/2-104 states, "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission. (b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm."

Section 5/2-201 states, "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named, approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record."

Section 112.30 of the Adm. Code states, "To provide the highest possible quality and humane and rehabilitative care and treatment to all recipients in the care of the Department and to promote public health and safety, all recipients in Department facilities shall receive comprehensive physical and dental examinations."

Section 5/2-112 states, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

Section 1-101.2 states, "'Adequate and humane care and services' means services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others."

Section 117.1 states, "'Neglect' means the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition."

Investigation Information for Allegation 1

Allegation 1: Staff at Chester Mental Health Center confiscated a recipient's Bible. To investigate the allegation, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and the Chairman of the facility's Human Rights Committee (Chairman). The Team reviewed the recipient's clinical chart, with his written authorization, and the facility's Patient Handbook.

Interviews:

Recipient:

According to the recipient, he had a Bible when he was admitted to the facility in August 2007. He informed the Team that the Bible was taken from him at the time of admission and has not been returned for his use.

Chairman of Human Rights Committee

According to the Chairman, when a recipient arrives at the facility all of his clothing and personal property are inventoried. All of the recipient's clothing is sent to the facility laundry for washing, and all personal property is sent to the property control supervisor for storage. The Chairman stated that if a recipient wants something out of his personal property, he can speak to his therapist in order to obtain the desired item. However, each recipient is allowed to have a Bible in his room.

Record Review

According to the recipient's 08/31/07 Treatment Plan Review (TPR), the recipient was admitted to Chester Mental Health Center on 08/31/07 from a county jail. His admission status was listed as Unfit To Stand Trial (UST). Documentation indicated that this was the recipient's second admission to the facility.

In the Extent To Which Benefiting From Treatment Section of the recipient's 10/19/07 TPR, documentation indicated that the recipient received medication for agitation on 09/02/07 at 5:45 AM and was noted to be pacing and chewing on toilet paper.

During the review of the recipient's 08/31/07 Personal Property Inventory, the Team noted that a Bible was not listed as a part of the recipient's personal property. Nor did the Team observe any documentation in the recipient's clinical chart that indicated that he had been restricted from having a Bible due to the pica behaviors listed in the 10/19/07 TPR.

Patient Handbook

The Authority reviewed the Clothing/Personal Property Section of the facility's Patient Handbook. It states that, "Upon arrival, all of your personal property is inventoried and sent to our property control supervisor for storage. At admission, if you have a Bible, you may take it with you on the unit. If you wish to have something out of the personal property, talk to your therapist."

When the Authority reviewed the Contraband Section of the Patient Handbook, a Bible was not listed as contraband.

Summary of Allegation 1

According to the recipient, when he was admitted to the facility his property included a Bible. The recipient informed the HRA that staff at the facility took the Bible from him and did not return it. When the HRA reviewed the recipient's Personal Property Inventory at the facility, a Bible was not listed. According to documentation in the recipient's clinical chart, the recipient has some pica behaviors of eating papers. However, the Authority did not observe any documentation in progress notes and restriction notices to indicate that the recipient's Bible was confiscated due to the pica behaviors. According to the Patient Handbook, a Bible is not considered contraband, and each recipient is allowed to have a Bible in his room.

Conclusion to Allegation 1

Based on record review and interviews during the course of the investigation, the Authority does not substantiate that staff at Chester Mental Health Center confiscated a recipient's Bible. No recommendations are issued.

Suggestion

The Authority suggests the following:

1. Whenever a recipient expresses concern about not having access to a Bible, the facility should provide a Bible for a recipient's personal use.

Investigation Information for Allegation 2

Allegation 2: The door to a recipient's room was locked during the day preventing him from entering the room. To address the allegation, the Team spoke with the recipient whose rights were alleged to have been violated and the Chairman of the facility's Human Rights Committee. The recipient's clinical chart was reviewed.

Interviews:

Recipient:

When the Team spoke with the recipient about the allegation, he stated that the door to his room was locked during the daytime hours; however, he was allowed to go into the room at night to sleep. He informed the Team that he is the only recipient on the unit who had restricted access to his room, and he could not understand the reason that these limitations have been imposed.

Chairman

According to the Chairman, the recipient flooded his room with water, as well as smeared feces and urine throughout the entire area. He stated that as a result of those behaviors, some limitations were imposed. He informed the Team that the recipient's clinical chart would contain documentation regarding his behaviors.

Record Review:

Treatment Plan Reviews

According to a 09/21/07 TPR, the recipient in his twenty-one days at the facility had displayed a vast array of unusual behaviors. He had been physically aggressive, exhibited pica behaviors, and displayed poor adult living skills. Documentation indicated the recipient was being kept out of his room during the daytime hours and allowed to return during the hours of sleep. According to the record, three times the week prior to the TPR meeting, housekeeping had to be called to clean his room because he had smeared feces and urine all over the walls and floor. Additionally, a plumber had to be called after he flooded his room. The following is documented: "When asked about these incidents, the patient responded belligerently that we had no right to turn the water off in his room. Also, the patient made it very plain that he didn't wish to cooperate with staff. The current behavior that is being seen here is very similar to that which was seen at the [NAME] Jail."

In the 09/21/07 TPR, the recipient's diagnoses were listed as follows: AXIS I: Bipolar Disorder, (most recent episode manic) and History of Schizoaffective Disorder; AXIS II: Deferred; AXIS III: Severe Erythema (rash in groin area); AXIS IV: Unfit to Stand Trial (UST), Incarceration, and Chronic Mental Illness.

The recipient's medications were listed as follows: Risperidone 2 mg twice daily for psychosis, Depakote 1000 mg twice daily for mania, Lorazepam 2 mg twice daily for anxiety and Haldol 5 mg every 4 hours, as needed, for agitation.

The TPR contained a goal for the recipient to be restored to a level of fitness to stand trial by 02/28/08. According to the TPR, the Treatment Team determined that if the recipient takes medication prescribed to treat the Schizoaffective Disorder, he would be able to achieve fitness to stand trial. The recipient's Psychiatrist reported that the recipient was compliant in taking his medication and his mania and aggression control had improved. However, he had smeared feces in his room. The Psychiatrist documented, "This is presumed to be a behavior that is intentional a purposeful as opposed to a regressed psychotic manifestation. We have locked him out of his room as of 09/26/07." Additional documentation indicated that "The recipient's aggressive behaviors which were seen initially have subsided, and his current behaviors are more of an aberrant nuisance variety."

Documentation in the Extent to Which Benefiting From Treatment Section of the 10/19/07 TPR indicated that the recipient was admitted to the facility on 08/31/07 in shackles. He was hostile, loud and threatening at the time of the admission. He was escorted to the restraint room and placed in full leather restraints after he tried to kick staff shortly after he arrived. On 09/03/07, as a result of the recipient flooding his room, water was turned off in the room. On 09/08/07, the recipient was observed dipping his shirt in the toilet in his room and sucking the fluids from it. The recipient smeared feces on the walls and smeared urine all over the floor in his room on 09/20/07. Documentation indicated that on 09/30/07, the recipient's floor and clothing were wet with urine. He was given clean clothing and later in the day he was observed playing with water in his toilet. When the recipient repeatedly slammed the door to his room, staff intervened and attempted to calm him; however, he barricaded his room and assaulted staff when they entered the area. The record indicated that the recipient was placed in full leather restraints after this action. As a result of the continued bizarre and aggressive actions, the recipient's medications were modified in an effort to improve behaviors. Depakote was increased to 1500 mg twice daily and Risperidone was increased to 3 mg twice daily. Treatment interventions, such as the recipient being locked out of his room during AM hours, furniture removed from the room due to his soaking it with urine, clothing removed from his room, and water turned off, were implemented. Documentation indicated that the Treatment Team reviewed the restrictions on a weekly basis.

According to the record, the recipient's behaviors remained impulsive and on 09/27/07 he tore his sink off the wall, used a bar of soap to fill the screen in his room and during the night urinated on the window. He was placed on 1 to1 observation, which continued until 10/11/07. Frequent observations during hours of sleep were implemented after the 1 to1 observation was discontinued. When the recipient's behaviors became more stable, he was moved to another module on 10/17/07 and all observations were discontinued. Documentation indicated that when the October 2007 TPR meeting was conducted, the recipient's behaviors and clinical condition had shown substantial improvement. He no longer engaged in impulsive behaviors, displayed frequent agitation or urinated on himself.

Progress Notes

Documentation in Progress Notes in the recipient's clinical chart was in accordance with the behaviors listed in the recipient's 09/21/07 and 10/19/07 TPR.

According to a 10/19/07 Progress Note, frequent observation was discontinued and the recipient was allowed to go to his room in the daytime hours beginning 10/16/07.

Additional Documentation

The recipient's record indicated that physician's orders were issued for the following: (1) The recipient should not be allowed into his room during the daytime hours; (2) Items should be removed from the room; (3) The water should be turned off in his sink and bathroom stool; and (4) the 1 to 1 observation implemented.

Restriction of Rights Notice(s):

During the record review, the HRA did not observe any Restriction of Rights Notices pertinent to the recipient being restricted from his room during the daytime hours. According to the facility's Procedure For Operation Guidelines For Use of Restraints, a Restriction Notice is to be used to give notice of any restriction or right to a recipient, a recipient's guardian, and to persons or agencies designated by the patient.

Summary

According to the recipient, the doors to his room were locked during the daytime hours prohibiting him from entering the area. The Chairman of the facility's Human Rights Committee acknowledged that for a period of time the recipient was not allowed to enter his room during the day. He informed the Team that the restriction was implemented because the recipient had smeared feces and urine on the walls and floors of his room and had flooded the entire area. According to the documentation in the recipient's clinical records, the recipient had exhibited bizarre and aggressive behaviors, such as smearing feces and urine, flooding his room, placing items in the toilet, and destroying property. As a result of the recipient's actions, the Treatment Team and a facility physician made a decision and issued orders to restrict the recipient from his room during the daytime hours. The Treatment Team, on a weekly basis, reviewed the restrictions and those restrictions were discontinued when the recipient's behaviors improved after a period of four weeks. The HRA did not observe any documentation that indicated that a Restriction of Rights Notice was given relevant to the recipient being locked out of his room.

Conclusion

The HRA believes that based on the recipient's documented behaviors, the facility's restriction of access to his room was appropriate and implemented as a protection for the recipient as well as for others. However, since the recipient's rights to be provided with services in the least restrictive environment were restricted, the facility should have provided the recipient with the Code required Restriction of Rights Notice. Therefore, the allegation that recipient's room was locked during the day preventing him entering the room is substantiated.

Recommendations

The following recommendation is issued:

1. Chester Mental Health Center should provide a recipient with a Restriction of Rights whenever any rights are restricted.

Investigation Information for Allegation 3

Allegation 3: The recipient did not have water in his room and in the stool in his bathroom. To investigate the allegation, the Team spoke with the recipient and the Chairman. The recipient's clinical chart was also reviewed.

Interviews:

Recipient:

When the Team spoke with the recipient whose rights were alleged to have been violated, the recipient stated that he had water in his room and in the stool in his bathroom when he arrived at the facility. However, within a short time after his arrival, the water was turned off in both areas while other recipients continued to have water.

Chairman:

According to the Chairman, water in the recipient's room was turned off because the recipient had flooded his room, stuffed items in the stool, and tore the sink from the wall. The Chairman informed the Team that the restriction was time limited, and when his behaviors and clinical condition improved, the restrictions were lifted.

The Chairman stated that the recipient still had access to water and a toilet. He was allowed to go to a toilet on the module with staff accompanying him and flushing the stool. The Chairman stated that the recipient was also allowed access to water in areas other than his room with staff supervision.

Record Review

Documentation in the recipient's September and October Progress Notes and TPRs indicated the following: 1) On 09/03/07, the recipient flooded his room with water. A plumber had to be called after the flooding. 2) On 09/08/07, the recipient was observed dipping his shirt in the toilet in his room. 3) On 09/15/08, the recipient stuffed a pair of socks in the toilet. It was necessary for a plumber to be called once more. 3) On 09/27/07 he tore his sink off the wall. 4) When he was found on 09/30/07 in urine soaked clothing and urine over his floor, he was given clean clothing and the room was cleaned. Later in the day he was observed playing with water in the toilet.

Documentation indicated that as a result of the recipient's bizarre and aggressive behaviors, changes were made in his medication in an effort to improve his behaviors. Additional treatment interventions were implemented. The recipient was not allowed to enter his room during the daytime hours. His furniture and clothing were removed from his room and the water was turned off. He was allowed to return to his room for sleeping in a bed that was returned to the room. The recipient was also placed on 1 to 1 observation on 09/30/07.

The record indicated that the 1 to 1 observation was continued until 10/11/07 and frequent observation during hours of sleep was implemented when the 1 to 1 observation was discontinued. When the recipient's behaviors and his clinical condition became more stable, he was moved another module on 10/17/07 and all observations were discontinued.

Documentation in the 10/19/07 TPR indicated that recipient's behaviors and clinical condition had shown substantial improvement. He no longer displayed frequent agitation and impulsive behaviors, and his incontinence had ceased.

According to the record, the recipient's Treatment Team reviewed the restriction on a weekly basis.

Restriction of Rights Notice(s)

During the record review, the HRA did not observe any documentation that indicated that a Restriction of Rights Notice was provided to the recipient when the water was turned off in his room and the water was removed from his bathroom stool. According to the facility's Procedure For Operation Guidelines For Use Of Restraints, a Restriction Notice is to be used to give notice of any restriction of rights to the recipient, his guardian and to persons or agencies designated by the recipient.

Summary of Allegation 3

According to the recipient, he was not allowed to have water in his room or in the stool in his bathroom. When the Team spoke with the Chairman about the allegation, he stated that it was necessary to turn of the water because the recipient had flooded his room and caused considerable damage to the area. The Chairman related that with staff supervision the recipient had access to a toilet and water on the unit. According to the recipient's records, he flooded the room, torn the sink from the wall, played in the bathroom stool, and dipped his shirt in the stool, then sucked the water from it. As a result of these actions, the water was turned off in both areas, and interventions, such as changes in medication and monitoring, were employed in an attempt to assist the recipient in becoming clinically stable. The record indicated that on a weekly basis the Treatment Team reviewed the restrictions. Documentation indicated that when the recipient's behaviors and his clinical condition improved, the restrictions were lifted, and he was moved to a less restrictive area of the facility. The HRA did not observe any documentation that indicated that the recipient was provided with a Restriction of Rights Notice.

Conclusion of Allegation 3

The Authority acknowledges that the facility appropriately implemented the restriction for the protection to all recipients and to facility property. Conversely, since the recipient's rights to be provided with services in the least restrictive environment were restricted, the facility should have provided the recipient with a Restriction of Rights Notice. Therefore, the allegation that the recipient did not have water in his room and in the bathroom stool in his bathroom is substantiated.

Recommendation

The following Recommendation is issued:

1. The facility should follow the Code's requirements by providing a recipient with a Restriction of Rights Notice whenever any of the recipient's rights are restricted.

Allegation 4: The recipient had a broken clavicle (collarbone) that was not treated. To investigate the allegation, the HRA spoke with the recipient and the Chairman regarding the allegation. The HRA team, which includes a Registered Nurse, reviewed documentation from the recipient's clinical record. Facility policies pertinent to the allegation were reviewed.

Interviews:

Recipient:

The recipient informed the Team that facility medical staff members have failed to provide treatment for his broken collarbone. The recipient stated that the injury occurred when he fell from a bicycle he was riding prior to his incarceration.

Chairman:

The Chairman informed the HRA that the recipient received a broken clavicle prior to his hospitalization. He stated that after medical staff was informed of the recipient's injury, a facility physician examined the recipient and ordered x-rays. The Chairman informed the Team that based on the x-ray findings no additional treatment was administered.

Chart Review

Psychological Evaluation

According to a Psychological Evaluation conducted on 08/13/07 while the recipient was in the county jail, the recipient informed the psychologist that he suffered from diabetes and a broken shoulder. He reported numerous other minor injuries and stated that he had undergone surgery for the removal of a cyst on his tailbone.

The psychologist reported that the recipient had a deep cough, a bruise under his right eye, a large bruise on his left forearm and his left collarbone seemed "misshapen".

Assessments Upon Admission

The recipient's record indicated that a Medical Doctor conducted a thorough physical examination on the day of the recipient's admission to the facility. The admitting nurse obtained the recipient's temperature, pulse, respiration and blood pressure while the recipient was in the infirmary. The admitting nurse examined the recipient to determine for infectious disorders and obtained a medical history. The following additional screenings were conducted within twenty-four hours of his admission: vision, hearing, speech, nutritional, accident/fall assessment, bowel function and elimination, psychosocial, psychiatric evaluation, occupational, physical therapy, spinal and nursing assessment. A personal safety plan and a discharge plan were completed at the time of admission.

Documentation indicated that the recipient had a history of a fracture clavicle; however, there were no problems noted at the time of admission.

Progress Notes & Physician's Orders

In a medical progress note dated 09/19/07, a facility physician documented that when the newly admitted recipient was examined the recipient stated that he had a fracture of his left clavicle. The recipient informed the physician that the injury had occurred when he fell off his bicycle on 08/01/07, which was prior to his incarceration at the county jail and subsequent hospitalization at the facility. The physician documented that the recipient stated that he had no pain in the clavicle or shoulder area. After speaking with the recipient, the physician ordered x-rays of the left clavicle.

Additional medical progress notes as well as physician's orders indicated that supplementary x-rays were ordered on 10/12/07 and 12/12/07.

The HRA did not observe any documentation that indicated that any treatment was administered after the x-rays findings were obtained.

Radiology Reports

Findings in the 09/19/07 Radiology Report indicated that the recipient had a displaced fracture of the distal clavicle with suggestion of mild healing. Findings in the 10/12/07 Report remained the same as recorded in the 09/19/07 Findings. In the 12/12/07 Radiology Report which included x-rays of the shoulder as well as the clavicle, indications were that the recipient had a moderately displaced distal clavicle fracture showing no change in the position of the fragments and an increase in soft tissue calcification along the inferior aspect of the fracture site.

Treatment Plan Reviews (TPRs)

The recipient's 09/21/07 TPR contained a goal to promote healing of open areas, laceration, surgical incision sites and to improve and promote healing of skin lesions to address the recipient's alteration in skin integrity. Documentation indicated that Nystatin-Triamcinolone Cream was to be applied to the groin area twice daily and the antibiotic, Doxycycline, 100 mg twice daily was administered. The record indicated that the rash in groin area had improved; however, treatment was needed for athlete's feet. There was no documentation in the TPR regarding the recipient having x-rays or treatment for a broken clavicle

According to the recipient's 10/19/08 TPR, the recipient's groin rash had healed and the Athlete's feet condition had improved. Documentation indicated that treatment for Athlete's feet would continue. The HRA did not note any documentation in the TPR pertinent to the recipient's broken clavicle.

Information from the Mayo Clinic Website

According to the MayoClinic.com website, the clavicle (collarbone) connects the upper part of the breastbone (sternum) to the part of the shoulder blade. Signs and symptoms of a broken collarbone may include the following: (1) immediate pain and swelling in the area of the fracture, (2) a crackly or grinding sound in the affected area when the shoulder is moved. (3) the shoulder sagging forward and downward, (4) and a snapping sound that occurs at the time of the fracture. Documentation indicated that the physician might diagnose a broken collarbone by a physical examination and x-rays.

The record indicated that the treatment for a broken clavicle includes the use of an arm sling, ice on the affected area, pain relievers (as needed) and avoidance of contact activity for four to six weeks after the injury. According to the documentation, elaborate shoulder harnesses are unnecessary for collarbone injuries. Rarely, a broken collarbone might require surgery.

Facility Policy

The facility's policy/procedure entitled, "Admission of New Patients" was reviewed. According to the Policy Statement, "Chester Mental Health Center maintains a uniform, clinically appropriate process to admit new patients."

A new patient is defined as an individual who have never been a recipient, a recipient who has been transferred to another facility and returned, and a recipient who has been sent to court and returns after the absence of more than 60 days.

The Policy mandates that all new admissions be admitted through the Infirmary. According to the outlined procedure in the Policy, a recipient is asked to undress and shower before he is issued new clothing items. After he is dressed, a STA will escort him into the

examination room where the STA will record the recipient's height, weight, wrist circumference, and clothing measurements and provide the results to the admitting nurse. The admitting nurse will obtain the recipient's vital signs and document if he has any scars, tattoos, injuries and identifying marks. A complete medical history and a list of the recipient's medications will be obtained. The recipient will also examined for the presence of pediculosis capitis (lice), scabies, and infectious disorders. The following assessments will be conducted: spiritual, educational/vocational, nutritional, psychiatric, accident/fall risk, visual, dental, bowel elimination, and hearing/speech.

A facility Medical Doctor (MD) will conduct a physical examination of the recipient before he is transferred from the infirmary to the unit of place. If the examining MD feels that the recipient should not go to the unit immediately, orders will be written for treatment, and the recipient will be remain be considered an admission to the infirmary and remain in that area for the treatment. A facility psychiatrist will conduct a psychiatric evaluation within twenty-four hours of the recipient's admission to the facility.

Summary

According to the recipient, he received a broken clavicle on 08/01/07 when he fell from his bicycle. The injury occurred prior to his admission to Chester Mental Health Center on 08/31/07. Upon admission to the facility, various assessments were conducted in accordance with facility policy. Documentation indicated that the recipient had a history of a broken clavicle; however, there were no presenting problems at that time. The HRA did not observe any documentation that indicated that the recipient was required to remain in the infirmary for treatment. When the recipient reported to staff on 09/19/07 that he was having problems with the broken collarbone, a facility physician examined him on the same day and ordered x-rays. The physician recorded that when he examined the recipient, a diagnoses of a broken clavicle was made. According to the physician's report, when he asked the recipient if he was experiencing any pain, the recipient replied that he had no pain. The record indicated that two additional x-rays were completed on 10/12/07 and 12/12/07. Findings indicated that the recipient had a broken clavicle with healing in process. According to the Mayo.Clinic.com website, x-rays and examination are standard diagnostic tools to determine if an individual has a broken clavicle. Treatments include use of an arm sling, application of ice to the affected area, pain relievers (as needed) and avoiding contact activity for four to six weeks.

Conclusion

Since the injury occurred over four weeks prior to the recipient's hospitalization, some of the standard treatment may have not been implemented. Based on information from the Mayo.Clinic.com website and the HRA's review, which included the expertise of an RN on the HRA Board, the Authority believes that additional treatment may have not been warranted at the

time the recipient was examined by the facility physician. The HRA did find that the facility conducted assessments as a result of the recipient's reported concern. Therefore, the Authority concluded that the recipient's right to humane care and treatment pertinent to the broken clavicle was not violated. No recommendations are issued.

Suggestion

The Authority offers the following suggestion:

1. Documentation in the recipient's chart should indicate that based on examination and test results, additional treatment(s) were not warranted and the reasons stated.