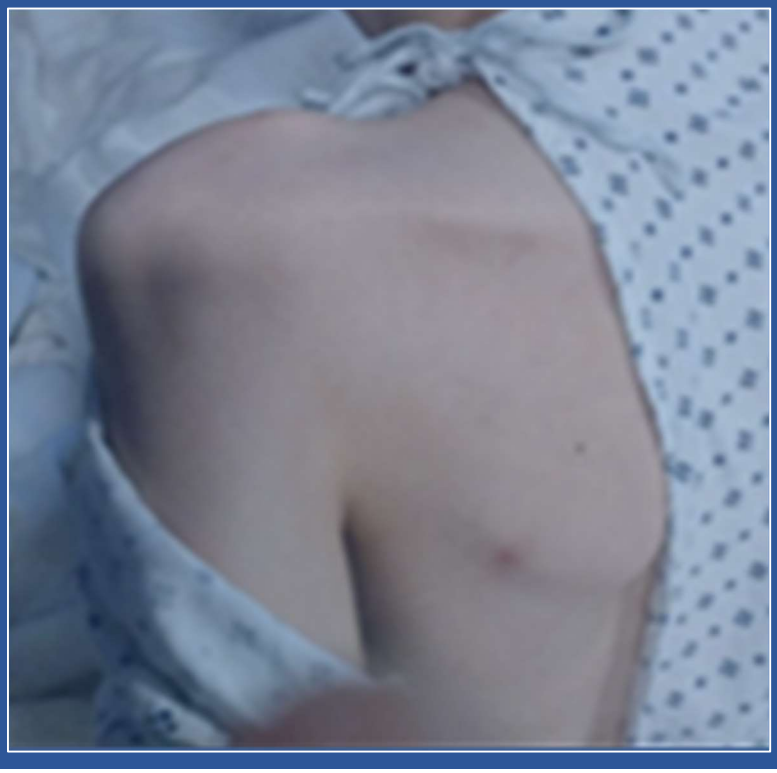
Malnourished:

The Recurrence of Malnutrition at a Large, State-run Facility for Individuals with Intellectual and Developmental Disabilities



Executive Summary

Disability Rights Arkansas (DRA) conducted a multi-year review of the Conway Human Development Center (CHDC) after receiving repeated allegations of malnutrition, unexplained weight loss, and avoidable hospitalizations. Sparked by three serious complaints in 2023-2024, the review expanded when DRA noted that 32% of CHDC residents who died between February 2023 and February 2024 were underweight at the time of death, and that CHDC repeatedly failed to acknowledge or correct deficiencies even when notified directly. An additional hospitalization for malnutrition in late 2024 and a total of 12 cases of malnutrition from February 2023 to January 2025 further signaled a systemic breakdown in clinical oversight, nutrition management, and administrative accountability.

DRA's investigations found that CHDC's dietary and mealtime systems are fundamentally inadequate, characterized by poor documentation, infrequent or inconsistent monitoring, outdated or incorrect diet orders, and a lack of meaningful oversight by supervisory and clinical staff. These failings were not isolated but reflected deeply entrenched structural issues, including an untenable caseload for a single dietician, contradictory training for staff, inaccurate height/weight measurements, insufficient processes for identifying weight loss, and the near absence of quality assurance mechanisms.

Despite repeated communication and the provision of a draft report to the Division of Developmental Disabilities Services (DDS), the agency declined to acknowledge errors, commit to corrections, or adopt recommendations. DDS's response focused narrowly on disputing contextual details rather than addressing underlying problems, reinforcing DRA's concern that meaningful reform will not occur internally without outside pressure and oversight.

Four case studies demonstrate how these systemic failings directly harm residents—some of whom became severely emaciated, developed pressure wounds, required feeding tubes, or experienced dangerous medication interactions. In several cases, hospital staff noted that CHDC's dietary care was insufficient to maintain basic health, and external providers expressed concern that CHDC had not been meeting residents' minimal nutritional needs.

Systemic failures include:

- Incorrect or outdated diet orders left in place for months.
- Inaccurate or delayed food-intake logs, sometimes contradicting video evidence.
- Failure to follow hospital recommendations for supplements, diet textures, or medical follow-up.
- Inconsistent or clinically unsafe diet textures prescribed, including substituting a "chopped" diet when a purely pureed diet was required.
- Rushed or prematurely terminated mealtimes, with residents denied alternatives or supplements.
- Inaccurate weights and BMI calculations, including errors as large as 27 lbs.
- Lack of functional oversight committees, such as the Weight Committee, which lacked minutes, tracking, or continuity.

- Insufficient staffing, with only one dietician for more than 400 residents, including individuals who are medically complex.

Across all levels—direct-care, clinical, managerial, and oversight—CHDC failed to maintain basic standards necessary to prevent nutritional decline in an at-risk population.

Given these findings, DRA concludes that CHDC's practices place residents at significant and ongoing risk of harm, and that internal systems cannot be relied upon to self-correct. Robust, external involvement from state and federal oversight entities, as well as community scrutiny, is necessary to restore safety and accountability.

Accordingly, DRA recommends systemic reforms related to staffing, oversight, clinical practices, and accountability to ensure a basic element of safety we should **all** demand from a state-operated institution.

Disability Rights Arkansas, Inc.

Disability Rights Arkansas

Disability Rights Arkansas (DRA) is the federally mandated and funded nonprofit organization serving as the Protection and Advocacy System (P&A) for individuals with disabilities in Arkansas. The P&A System is a network of 57 legal advocacy agencies authorized to protect human, civil, and legal rights of all individuals with disabilities, consistent with state and federal laws. DRA's abuse and neglect team provides advocacy services to individuals, monitors facilities, and investigates abuse and neglect.

DRA is committed to advancing the rights, inclusion, and well-being of Arkansans with disabilities. Through legal advocacy, investigations, public awareness, and policy change, DRA ensures that individuals with disabilities have equal opportunities to live, learn, and thrive in their communities.

Background

One of the settings DRA monitors is the state-run Intermediate Care Facilities (ICF). Arkansas has five large, state-run ICFs, called Human Development Centers (HDCs). The HDCs provide 24-hour care to individuals with intellectual and developmental disabilities. They are located in Arkadelphia, Booneville, Conway, Jonesboro, and Warren (Southeast Arkansas). These facilities are operated by the Arkansas Department of Human Services (DHS), Division of Developmental Disabilities Services (DDS) and are under the control and administration of the DDS Board.[1] HDCs are currently provided oversight by the Office of Long-Term Care (OLTC), another DHS entity.

Demographic Information	Arkadelphia HDC	Booneville HDC	Conway HDC	Jonesboro HDC	Southeast AR HDC
Population	105	117	431	107	86
Male	79	84	267	75	73
Female	26	33	164	32	13
Dual Diagnoses	73	115	311	92	74
Profound*	51	21	251	40	26
Severe*	17	37	80	17	20
Moderate*	17	28	66	27	20
Mild*	18	30	34	22	19
Adaptive Level of Function Listed as "Other"	2	1	0	1	1
Fragile Health	74	0	240	5	0

*Adaptive level of function as listed on DDS Board Reports

The Conway Human Development Center (CHDC) is the largest HDC, with a licensed capacity of 518 residents and a functional capacity of 470 residents. CHDC was founded in 1959 as the Arkansas Children's Colony. It is currently the only HDC in Arkansas to provide services for children.[2] Individuals with complex medical needs seeking placement at an HDC and residents of other HDCs who experience a decline in function will typically be placed at CHDC because of the facility's more expansive medical services compared to the other HDCs. CHDC has an on-campus infirmary where residents receive more medical supervision than they would within their residence.

Introduction

In November 2023, DRA began investigating an allegation of maltreatment in which a family was concerned that their loved-one had been neglected at CHDC, resulting in hospitalization for malnutrition. By June 2024, DRA had received two additional complaints characterized by unexplained weight loss and the need for hospitalization. These complaints, coupled with what appeared to be a lack of urgency and willingness to implement changes by the facility, when alerted to these residents' issues, launched a broader review by Disability Rights Arkansas (DRA).

DRA reviews all deaths of residents of HDCs. As a part of the reviews, death reports were screened more closely for indications of low weight.[3] If there was any indication that the resident was underweight at the time of death that was investigated further, as appropriate. Between February 2023 and February 2024, **seven out of twenty-two (32%) residents who passed away at CHDC were underweight at the time of death.**[4] These residents had various causes of death and underlying factors contributing to deaths, none of which were listed as malnutrition. However, it is important to note that being underweight can negatively impact a person's ability to heal and fight off infections. For example, a 2010 study found that "nutrition deficiencies impede the normal processes that allow progression through stages of wound healing. Malnutrition has also been related to decreased wound tensile strength and increased infection rates."[5]

Identified deficiencies related to the dietary and meal services at the facility along with specific concerns related to individual residents were discussed with administration, the facility dietician, and reported to the facility's oversight agency, the Office of Long-Term Care within the Department of Human Services (DHS OLTC). Very little acknowledgment or correction of any identified issues occurred. At the end of 2024 another resident was hospitalized due to malnutrition (they were also diagnosed with Depakote toxicity), prompting a resurgence of concern and highlighting the continuous systemic issues at the facility.

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[1]The DDS Board is made up of seven members, six members representing their district and one member at large. Board members are appointed by the Governor with the consent of the Senate to serve seven-year terms (AR Code § 20-48-203 (2024)). Current members can be found at this link: https://humanservices.arkansas.gov/divisions-shared-services/developmental-disabilities-services/dds-board/.

[2] "Arkansas Children's Colony." Central Arkansas Library System. Encyclopedia of Arkansas.

[3] Low weight is not always flagged in the documentation and internal death reviews completed by the facility. Therefore indicators such as orders for nutritional supplements, mentions in notes of weight loss, and recent g-tube placements were looked for as well.

[4] After DHS reviewed a draft of this report and provided feedback, they stated, "*Upon review of all deaths reported in the time frame indicated in the report, by CHDC, only five residents had a BMI that fell below normal range.*" DRA has records, from CHDC, that support seven residents in this category having a BMI that fell below normal range.

[5] Stechmiller, Joyce K. "Understanding the Role of Nutrition and Wound Healing." *Nutrition in Clinical Practice* 25, no. 1 (2010): 61–68.

Our limited review identified **12 cases of malnutrition[6] occurring between February 2023 and January 2025.**[7] These cases were identified through the examination of death records, police and incident reports, and allegations of maltreatment made directly to DRA. Systemic issues identified within the nutrition and dietary practices at CHDC, along with four case examples that show how real CHDC residents are being impacted are detailed below.

In addition to all of the ongoing communication with and reports to DHS and directly with CHDC, that are noted through this report, DRA met with the Director and Deputy Director of DDS on November 7, 2025. At that time they were provided with a copy of the draft report to review and given one week to provide feedback. Our goal in providing an advanced copy of the report, as explained to DDS during this meeting, was not only to ensure accuracy, but to give DDS an opportunity to understand and acknowledge the gravity of the deficiencies highlighted and commit to meaningfully addressing the concerns raised, either by committing to institute any of DRA's recommendations or proposing and committing to their own. They chose to do neither of those things.

Instead, their response, which focused on 11 specific facts from the report that they characterized as inaccurate or misleading, was exclusively used to "share added context and information." While we can agree on the importance of context and getting the facts right, the response reads more as an attempt to minimize the very serious and in most cases very avoidable conditions suffered by residents in their care. For example, DDS asked that it be noted that, "'oversedation' is not a medical diagnosis and was never listed on active problem/diagnosis list," during one minor CHDC resident's 25-day hospital admission. In this case "altered mental status" *was* listed as a diagnosis for this patient and his discharge instructions included: "During this patient's hospital stay he was found to be encephalopathic secondary to Depakote associated toxicity. In addition he was found to be ***overly-sedated*** with a large polypharmacy burden of multiple CNS-sedating medications." This was followed by a recommendation to discontinue six of his medications and reduce the dosage of a seventh in order to, "protect him from his potential self-harming behavior while also not overly-sedating him."

DRA does not feel that any of the "corrections" provided by DDS materially change the information presented or diminish the urgent need for change at CHDC. We do, however, always strive to be as accurate and comprehensive as possible and have therefore incorporated any additional information

[6] The American Society for Parenteral and Eternal Nutrition (ASPEN) defines pediatric nutrition as "an imbalance between nutrient requirements and intake, resulting in cumulative deficits of energy, protein, or micronutrients that may negatively affect growth, development, and other relevant outcomes. Based on its etiology, malnutrition is either (1) illness related (1 or more diseases/injuries directly result in nutrient imbalance) or (2) caused by environmental/behavioral factors associated with decreased nutrient intake/delivery (or both)." ASPEN defines adult malnutrition as acute, subacute or chronic state of nutrition, in which a combination of varying degrees of overnutrition or undernutrition with or without inflammatory activity have led to a change in body composition and diminished function."

[7] All death reports received during this time period were screened, however a comprehensive review of all residents was not performed and therefore the number of residents identified should not be considered a complete representation of underweight residents.

provided within the relevant sections and attached the full response to the end of this report. In most instances that information is also followed by additional clarifying or correcting information from DRA.

The lack of acknowledgement and accountability in the response makes a report like this even more important. If CHDC and DDS will not acknowledge the deficits in care that have occurred and commit to improving the quality of life for the residents they serve, it will be up to the community, to the public to hold them accountable.

Disclaimer: A comprehensive review of all residents at this large, state-run facility was not performed. DRA staff are not medical professionals. DRA's reporting is based on documentation by medical professionals employed by CHDC and outside agencies including hospital admission records, practitioner progress notes, nursing notes, doctor's notes, and physician's orders. Additional records created by the facility and completed by non-medical staff were also reviewed.

Dietary Practices

Through our monitoring and investigations, we have identified deficiencies in a few key areas, which are summarized below, they include:

1. Insufficient level of professional or clinical involvement in resident care
2. Inaccurate and insufficient documentation of food intake
3. Infrequent mealtime observations that are inconsistently documented
4. Failure to update and follow meal plans and serving size requirements
5. Failure to properly identify or train staff on diet textures
6. Rushed mealtimes
7. Insufficient processes for identifying and properly reporting resident weight loss
8. Insufficiently carried out plans to combat weight loss

CHDC employs one Dietary Services Director and one Clinical Dietician to oversee the nutritional care for its population of over 400 residents.[8] The Clinical Dietician is under the direction of the Dietary Services Director and "directs the activities of the kitchen, prepares menus and assists with management of a nutrition system, supervises personnel in large food service establishment (interviews, develops schedules, handles disciplinary action), and conducts training and education."[9] The Dietary Services Director oversees inventories, ensures equipment is maintained, makes budget estimates, analyzes nutrient needs of residents, formulates and revises policies, and evaluates and develops meal plans.[10]

Dietary Services Director Job Summary

1. Clinical Management of nutritional needs of resident population. 2. Implementation/Supervision of resident nutritional programs & education. 3. Administration/Direction of Food Services program/staff. 4. Special projects. 5. Professional growth. 6. Leadership skills. 7. Performs other duties as assigned.

Job Summary taken from CHDC Dietary Services Director job description.

DRA identified and reached out to a few of the other large facilities that serve similar populations in other states. The Shapiro Developmental Center in Illinois with a population of 466 shared that they currently have only one dietician but added that they are "running short." Caswell Developmental Center in North Carolina, with a population of approximately 250 residents, has 4 dieticians currently. Denton State Supported Living Center in Texas, with a population of 375 residents, also has 4 dieticians.

Due to the extremely large caseload, the dietician must rely on observations and documentation completed by other staff members, which can create several issues. As we saw in the case studies highlighted in this report, direct care staff can misreport food intake and weights, which in turn causes cues that would trigger a change in a resident's Diet Plan to be missed. While staff input regarding residents' eating habits and food preferences is valuable, it should be supplemental and never replace a dietician's direct assessment.

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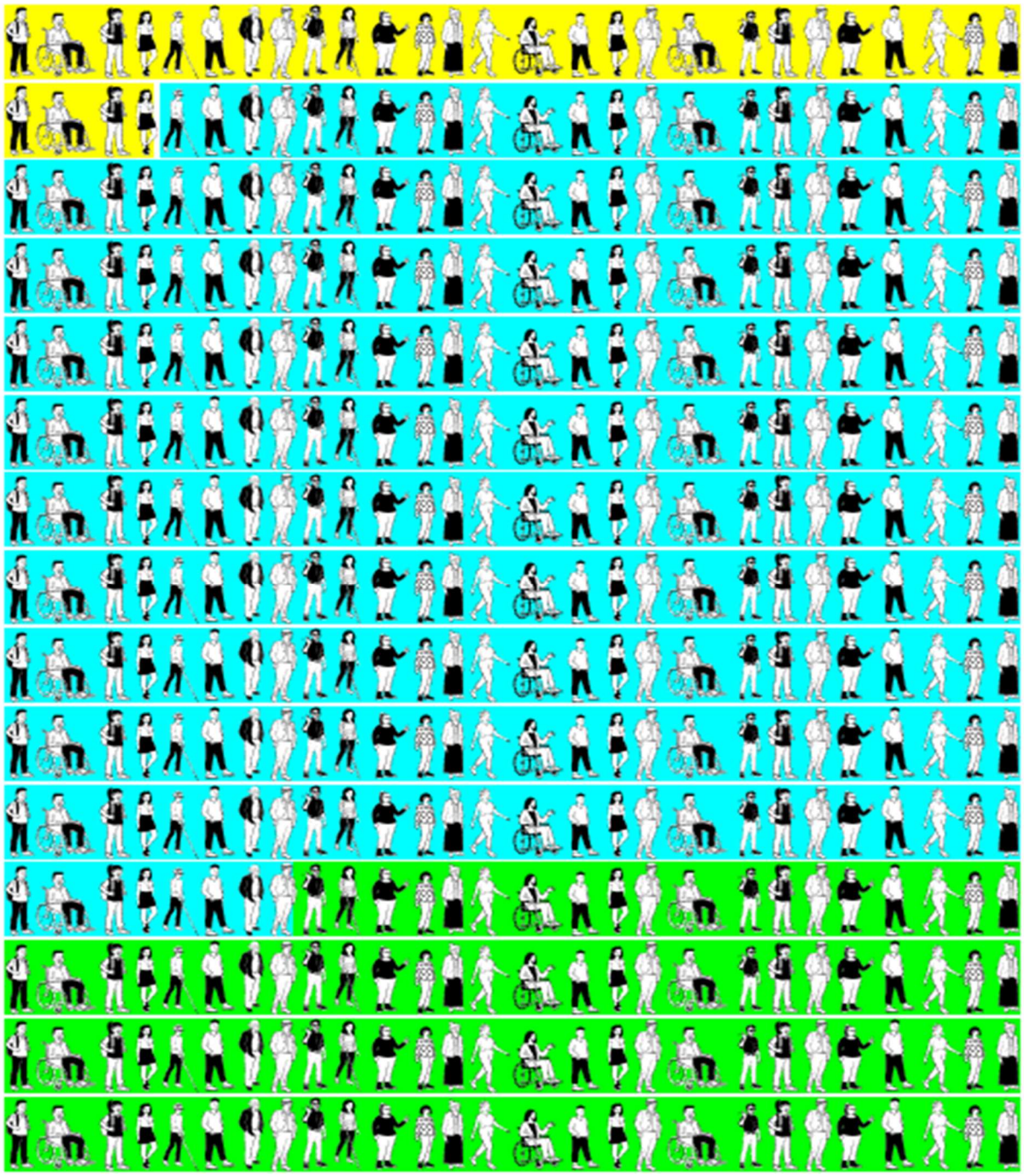
[8] CHDC is currently licensed for up to 518 residents but reports a functional capacity of 470. Over the last several years their population has stayed around 420. The Dietary Services Director stated to DRA that she had two clerical dietary assistance staff to help with collecting and inputting data and other tasks. When specific information including the names, dates of hire, and job descriptions for the clerical staff was later requested as part of our investigation, to ensure we had a complete and accurate understanding of the roles and responsibilities associated with Dietary Services, the facility did not provide any names or dates of hire and wrote "N/A" next to the request for job descriptions. After further attempts at clarification the facility responded that they "have never had anyone in the positions of dietary aides, assistants, or clerical staff, nor do they now."

[9] Arkansas Department of Human Services Functional Job Description for Division of Developmental Disabilities Clinical Dietician signed by current CHDC Clinical Dietician in August of 2023.

[10] Arkansas Department of Human Services Functional Job Description for Division of Developmental Disabilities Dietary Services Director signed by current CHDC Dietary Services Director in June of 2024.

The caseload at CHDC is not only large but is also complex. Only 8% (33 residents) receive a “regular” diet, 67% (281 residents) receive a “modified” diet, and an additional 25% (104 residents) are “tube fed.”[11] The visual on the following page represents this breakdown, showing the number of residents who receive a “regular” diet as yellow, “modified” diet as blue, and those that are “tube fed” green.



[11] DDS Board Report for February 5, 2025 reflecting facility statistics for October, November, and December 2024.

Documentation of Food Intake

Daily food intake is monitored by direct-care staff, who provide meals to the residents within their residence. Direct-care staff are responsible for documenting the amounts of food and liquids consumed by the residents after every snack and meal on Food Intake logs. The facility dietician reviews the logs and alerts a resident's Speech Language Pathologist (SLP) if a decrease in food intake is noticed. If food intake is not accurately documented, staff may miss signs that a resident is not eating or drinking enough, which can lead to weight loss, muscle wasting, or even life-threatening complications. Furthermore, the inaccuracy of the food-intake logs can delay necessary interventions like nutritional supplements or changes in dietary plans.

DRA has observed a total of 18 mealtimes at CHDC between December 2023 and October 2025. During these observations, DRA staff never witnessed staff documenting the amount of food and liquid consumed prior to the residents' trays being cleared and the residents leaving the dining area. Instances in which Food Intake Logs were not completed for up to 15 days after the mealtime service were identified and reported to OLTC.[12]

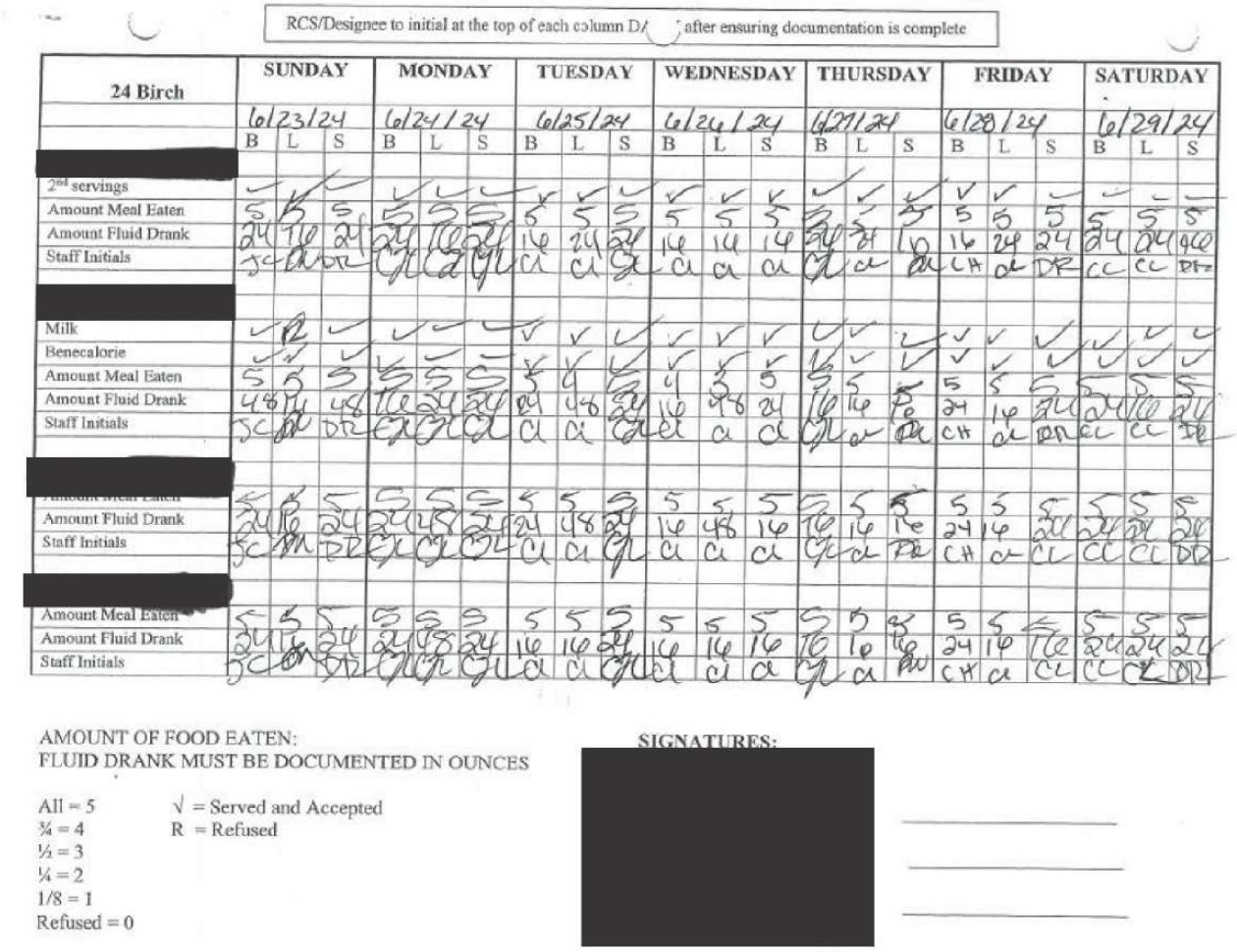
Photo of kitchen and dining area in one of the cottages at CHDC.

[12] During monitoring on 11/20/2023, DRA staff noted that Food Intake Logs for all residents in a cottage had not been recorded for breakfast, lunch, dinner, or snacks on 11/5/23, 11/6/23, and 11/18/23. DRA shared this information in our 12/4/2023 complaint to OLTC, but OLTC did not identify any issues with mealtime documentation in their complaint survey.

There can be up to 15 residents eating at one time and many can, and will, clear their plates in the trash when they are done, with little or no warning. In some of the cottages the Food Intake Logs are kept in a binder that is not stored in the kitchen. In order for the logs to be accurately completed the staff member completing them would have to have been able to closely observe all residents and note whether they received all food, supplements, drinks, and second portions that are ordered and how much of each they consumed, memorize that information, and then locate and complete the logs at a later time.

During meal service direct care staff are tasked with:

- Setting up the steam table,
- Checking and documenting food temperatures,
- Ensuring all Eating Plans are followed, including modified textures and consistencies, and that the correct supplements, utensils, and adaptive equipment are provided,
- Providing supervision to residents,
- Providing direct assistance to or feeding residents as required,
- Storing and disposing of leftover food, cleaning the kitchen, and washing the dishes.



Food Intake Log for four residents completed by CHDC staff.

The delayed documentation increases the likelihood of errors or inaccuracies in food intake reporting. DRA has identified numerous discrepancies between DRA's direct observations at mealtimes and what was recorded on the intake logs, calling into question the general accuracy of such logs.

Examples include:

- In September 2025, a resident was falsely documented as having eaten his entire lunch and dinner, when video surveillance showed that he had not eaten anything at all, likely due to not being offered any alternatives.
- A resident eating only a portion of his meat and leaving everything else but being documented as eating his entire meal.
- Supplements that were never provided being checked as served.[13]

The limited number of direct-care staff coupled with the high number of tasks required, in addition to general resident supervision, creates an environment where it would be easy for specifics of a resident's meal plan to be overlooked and where documentation is not prioritized.

Mealtime Observations

Mealtime observations are a vital tool in ensuring the health and safety of residents. It is the only way to monitor whether residents are receiving the ordered portions, textures, supplements, and adaptive equipment. Mealtime observations are also necessary to identify if and when changes are needed to residents' meal plans. For example, if a resident was frequently observed eating less than half of their plate at mealtimes, a nutritional supplement may be ordered to ensure that the resident is meeting his or her daily nutritional requirements.

The Dietary Services Director does not provide direct mealtime monitoring. When asked who provides direct mealtime observations, she stated, "I'm assuming that they have an RN. They have resident operations managers that do that, and then I think the nurses – the LPNs and RN. I don't know how they're assigned to be honest."[14] According to the dietician, Residential Operations Managers (ROMs)[15] send monthly reports on mealtime observations.[16] However, she was unsure how often ROMs perform these observations and did not provide further details on what these observations entail.

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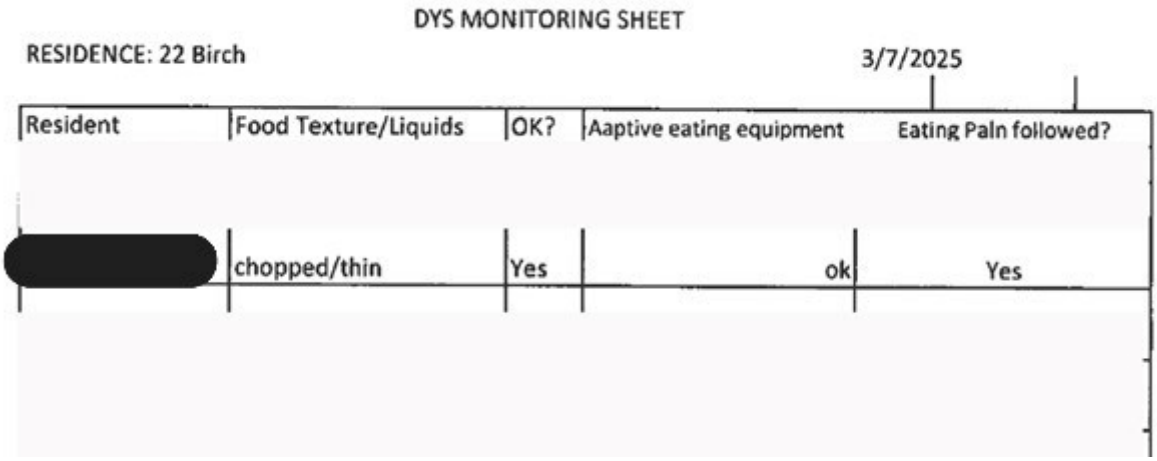
[13] DRA observed this during mealtime observations in November 2023 and February 2025.
[14] November 2023 interview of CHDC Dietician at CHDC.
[15] According to DHS's Functional Job Description (revised 5/2023), ROMs are responsible for monitoring client care, the observation of direct care staff in the residence, and ensuring documentation is completed. The minimum qualifications for this position are the "formal education equivalent of an associates degree in office administration, business management, facility maintenance or a related field; plus three years of experience in social service support programs, facility operations or a related field, including two years in a supervisory capacity."
[16] DRA is unfamiliar with any ROM monthly monitoring reports, as we have never received them in our requests that include residents' entire nutritional records.

Mealtime observations are conducted by speech-language pathologists (SLPs), who perform annual mealtime observations for residents without dysphagia and quarterly mealtime observations on residents receiving speech services for dysphagia.[17] Residents may also receive additional mealtime observations if changes in food intake are noted or at the request of a physician or direct-care staff.

Each SLP documents mealtime observations differently, as there is no designated form to ensure consistency in observations or documentation. According to one SLP interviewed by DRA[18], who has been employed at CHDC for 30+ years, she usually observes around 75% of the mealtime and may observe multiple residents' meals at once, depending on the need for observation. She then types her notes on a continuous log that contains observations for multiple residents and is kept in the individual SLP's office and not incorporated into each resident's individual record.


DYS MONITORING SHEET

RESIDENCE: 22 Birch

3/7/2025

Resident	Food Texture/Liquids	OK?	Aaptive eating equipment	Eating Paln followed?
[redacted]	chopped/thin	Yes	ok	Yes

Portion of SLP log of resident mealtime observations.

Due to a lack of standardized documentation for mealtime observations, SLPs may record differing information, potentially compromising the comparability of assessments. Furthermore, without a standardized mealtime observation document, it is unclear what information is considered essential, including basic information such as which meal was observed on a particular date (breakfast, lunch, or dinner). One SLP that was previously not documenting the time or for what meal an observation took place is now including that information in observation notes. This addition to a process the SLP had been completing for 20+ years was made after a DRA request for additional information/clarification to determine when an observation occurred. This example highlights a lack of quality assurance and insufficient training on documentation standards.

[17] This information was obtained through an interview with a speech pathologist at CHDC on 5/7/2025.
[18] This speech pathologist was interviewed at CHDC on 4/16/2025.

Meal Plans and Serving Sizes

The federal regulations for long-term care facilities state that food must be served "in appropriate quantity" and "closely match designated serving sizes on menus."[19] Although the regulation had already been in place for many years, the dietician reported to DRA that she had implemented the usage of labeled serving spoons to measure portion sizes in 2022. In November 2023, DRA reported to the dietician, who does not directly observe mealtimes and thus does not monitor staff's adherence to serving guidelines, that of the two cottages in which lunch was observed, staff in both failed to measure portion sizes with labeled serving spoons. Subsequent observations by DRA in 2023, 2024, and 2025 revealed that staff continued to use unlabeled serving spoons, suggesting that no corrective actions were taken to enforce adherence to proper serving protocols.

Photo of an 8-piece portion control serving spoon for sale on the JoyServe Amazon storefront. Photo by JoyServe.

DRA has also observed several instances in which residents did not receive nutritional supplements or alternative foods. On 2/5/25, DRA noted that no residents in 22 Birch (a children's cottage) were served nutritional supplements despite three residents' Diet Sheets indicating nutritional supplements should be offered at mealtimes. DRA reported these findings to the Assistant Superintendent, Dietary Services Director, and a facility APRN, who stated that this issue would be addressed. On 2/12/25, DRA observed another mealtime in 22 Birch to ensure that the issue had been resolved. However, we found that, again, no children received their nutritional supplements.

Residents should be able to choose their own food and drink when this does not contradict their individual medical and dietary restrictions and/or needs. In some instances, residents do not eat anything for mealtimes due to a lack of alternative foods or seemingly being overlooked by direct-care staff. On 11/20/23, DRA observed that a resident of 24 Birch was not offered alternative foods after he denied the menu items.[20] On 2/12/25, DRA observed that a resident in 22 Birch refused to enter the dining area with the other residents at the start of the meal. The resident remained in the dayroom for the remainder of the mealtime and was not prompted by staff to eat lunch. In video of breakfast, lunch, and dinner in 23 Birch (a children's cottage), DRA noted that one resident, who has documented food aversions, only ate at breakfast. For breakfast, this resident was not offered any foods from the menu and was handed a cereal bag of Froot Loops. The resident was not provided a bowl, plate, or any silverware. At lunch, this resident was, again, not offered menu items except for a small bowl of ice cream, which they denied. The resident was not offered any alternatives. At dinner, the resident was

[19] CMS Regulation §483.480(b)(2)(i)
[20] This issue was reported to the Office of Long-Term Care on 12/4/23.

offered menu items but declined to eat them. The resident was not offered any alternatives and left the dining area without having eaten lunch or dinner and without any meaningful attempts to honor their food preferences.

Food may also be used as a primary reinforcement for behavior, however federal regulations state that the food used as a reinforcement must be a part of a behavior plan and "consistent with nutritional parameters for that client." [21] Certain mealtime practices, if left unchecked, can cause more harm than good. While monitoring mealtimes DRA has observed staff serving soda and Hawaiian punch to residents, beverages that were not listed on the lunch menu. Staff were observed refilling residents' glasses multiple times with the soda and Hawaiian punch, without tracking who received how much of each beverage. Staff serving residents drinks high in sugar and artificial additives can spike blood sugar levels or exacerbate other health conditions that are unknown to them. Additionally, drinking large amounts during mealtimes can potentially lead to decreased food intake due to residents filling up on liquids rather than nutritious food items.

[21] CMS Regulation §483.480(a)(5)

Diet Textures

Training provided to staff on diet textures is confusing and contradictory. The chart[22] below was provided to DRA to demonstrate the definitions and examples of diet textures used at the facility. This chart describes a "chopped" diet as the following: "Moist, cohesive, no larger than a grain of rice, cream of wheat like, can a sauce [sic], gravy or condiment if additional moisture is needed." According to this chart, the size of "chopped" foods should be "relish-like, no larger than a grain of rice."

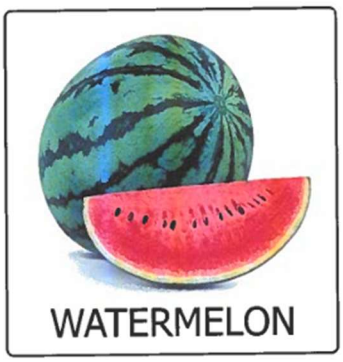
2.21.2025 Diet Textures used at CHDC

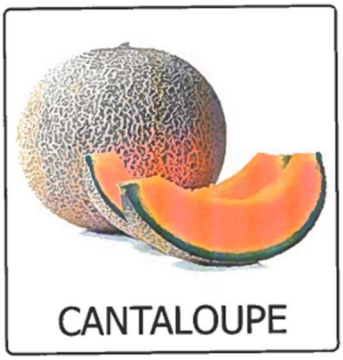
Term	How to prepare	Size	Description	examples
Regular	According to recipe	As prepared	No changes	Moist, tender cooked chicken breast
Diced ½" pieces	Cut by staff or dicing block	Cut into ½" pieces	Moist, tender pieces of food appropriately the width of a butter knife	Moist, tender cooked chicken breast cut in ½" pieces
Chopped	Prepared using food processor or comparable equipment	Relish-like, no larger than a grain of rice	Moist, cohesive, no larger than a grain of rice, cream of wheat like, can a sauce, gravy or condiment if additional moisture is needed.	Moist, tender chopped chicken prepared with gravy/sauce or added to finished product
Blended	Prepared using food processor or comparable equipment	No lumps, food is not sticky, pasty or runny	Smooth, pudding like, moist	Moist, tender cooked chicken prepared with gravy/sauce processed to smooth product with no lumps

However, the following photos were provided to staff for a visual demonstration of a "chopped" diet, showing chunks of watermelon, cantaloupe, and peaches that are obviously much larger than a grain of rice. It also shows photos of "chopped" vegetables, which are consistent with the chart's description of a "relish-like" food texture.

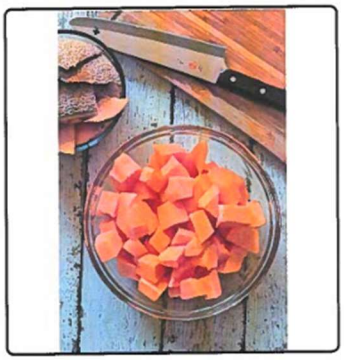
[22] While this chart was presented as part of CHDC's Policy Manual, in a later follow up with the facility, they stated that "CHDC does not have a policy on food textures; instead, you were provided staff training documents regarding diet textures."

CHOPPED FRUIT

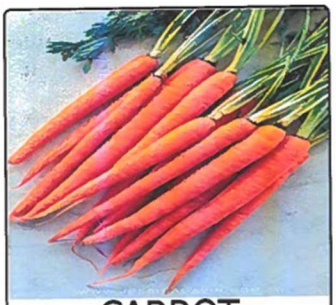

WATERMELON

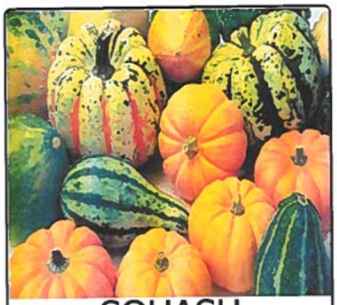

CANTALOUPE

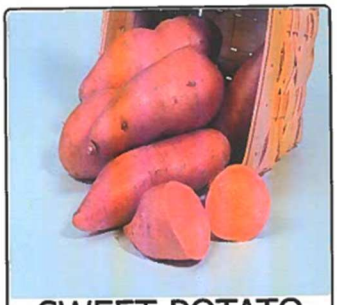

PEACHES

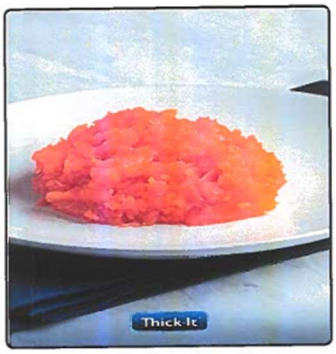


CHOPPED VEGETABLES


CARROT


SQUASH


SWEET POTATO



When following up on a resident who was determined to only be safe eating pureed foods during a recent hospital admission, DRA discovered that they were receiving a "chopped" diet at the facility. In response to our concerns, the facility stated, "[CHDC]'s diet is very close to what the hospital deems "pureed."' According to the International Dysphagia Diet Standardization Initiative (IDDSI), a Level 4 Pureed diet does not require chewing, has a smooth texture free of lumps, and can hold shape when placed on a spoon.[23]

Pureed carrots prepared by Lyons Health Labs and included in their catalogue of recipes for an IDDSI Level 4 Pureed diet.

There have also been issues observed with the ways in which foods are served to individuals not requiring altered diet textures. For example, being served whole boneless rib patties and only provided spoons while none of the direct care staff present in the kitchen offered to assist residents cut up the meat.[24]

Rushed Mealtimes

Mealtimes are often short, with one lunch DRA observed taking an entirety of 22 minutes from seating to all residents' plates being cleaned. Staff have been observed rushing or removing the plate from residents who eat at a slower pace. Some residents eat quickly or shove large quantities of food in their mouths without verbal prompts by staff to deter the residents from doing so. Residents have been observed coughing at mealtimes but receive no acknowledgement from staff.

On other occasions DRA has observed staff abruptly and inexplicably ending mealtimes. These observations were made by reviewing videos of mealtimes, which has proven to be an indispensable tool for monitoring what "normal" mealtimes look like without staff's knowledge that they are being monitored. Video footage for lunch in 22 Birch on 3/10/25 showed that staff feeding an underweight resident stood up and dumped the resident's tray into the trash, despite the resident's tray being nearly full and the resident giving no indication that they were finished.[25] Video footage for dinner in 23 Birch on 9/9/25 showed a resident being served an alternative meal, which was thrown away by staff after 5 minutes. While the resident did not consume any of the meal, dinner was not over and the resident continued to sit in the dining area until the other residents completed their meals.[26]

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[23] See the following handout from the International Dysphagia Diet Standardization Initiative detailing a Level 4 Pureed diet here: https://www.iddsi.org/images/Publications-Resources/PatientHandouts/English/Adults/4_pureed_adults_consumer_handout_30jan2019.pdf

[24] This was observed by DRA staff during an on-campus monitoring visit on 7/11/24.

[25] This resident is referred to as "Resident 4" later in the report.

[26] It should be noted that the staff member mentioned in this observation was terminated due to discourteous treatment of this resident. During this mealtime, the staff member was observed aggressively pulling the resident by his shirt into a utility

Identifying Weight loss

According to the Dietary Services Director, residents are weighed monthly, measurements are recorded on Height & Weight logs, and the logs are reviewed monthly. The dietician explained to DRA that she prints out the monthly weight records and highlights any significant changes, which she described as a resident losing 5% of their body weight in one month, 7.5% over three months, or 10% in six months. If a notable weight fluctuation is observed between months, she stated that she seeks to identify and address the resident's specific needs. This process relies on manually reviewing the paper Height & Weight logs from each residence and calculating percentages, which increases the likelihood of human error. Without a digitized system and automated alerts, there is a greater risk of missing something, such as failure to notice smaller fluctuations that gradually lead to significant changes in weight.

Instances of inaccurate height and weight measurements have been identified, which likely stem from a lack of staff training or facility-wide measurement guidelines. In one case reviewed by DRA, there was a 27.1 lb. discrepancy between the recorded weight by the facility and the weight recorded by a hospital during the resident's admission. This error likely stemmed from the facility's failure to verify the accuracy of scales and staff's failure to follow procedures, as staff had been instructed to subtract the weight of the wheelchair after weighing the resident in the wheelchair and seemingly did not, leading staff to mistakenly document the resident as 27.1 lbs. heavier than what he actually weighed.

In another case an 18-year-old resident's height, that had previously been records as 72.5" began being listed as 68". This discrepancy was enough to shift his BMI calculation from 19, at the bottom of the normal range, to 16, well within the underweight range. It is unknown how such a discrepancy in height could have occurred, given that there was no medical indication for why the resident's height would have decreased.

Additionally, DRA has received logs where the height was not filled in. Heights are only measured quarterly, but should be filled in every month, otherwise the dietician cannot be making the calculations she claims. A slight inaccuracy in height or weight can significantly impact a resident's calculated BMI, which the dietician seems to rely on when creating Meal Plans, Diet Orders, and other clinical determinations.

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closet twice when no other staff were present. DRA believes that this staff member threw away this resident's tray as a form of punishment. The resident was not engaged in any negative behaviors during the meal.

Plans to Combat Weight Loss

When a resident has been identified as experiencing significant weight loss, the dietician may recommend the resident receive a dietary supplement. This recommendation requires approval from a facility physician or nurse practitioner.

Residents' cases may be reviewed in CHDC's Weight Committee. According to a one-page document titled "Conway Human Development Center Weight Committee" it is chaired by the CHDC "Registered Dietician" and composed of registered nurses (RNs) for each treatment team, clinical speech pathologists, the Quality Assurance Nurse Practitioner, and a general Nurse Practitioner "or designee." The committee's goals are to: "identify residents with a weight loss or gain of greater than 5% within 30 days (or per facility protocol)," "flag any trends or patterns in weight fluctuations, recommend dietary modifications, medical evaluations, therapeutic interventions, or psychosocial support as needed," and "monitor the effectiveness of interventions at subsequent meetings." The committee's Continuous Improvement Plan is to "identify systemic or facility-wide issues that may affect resident weights," "recommend staff training, menu adjustments, or policy updates as needed," and "track outcomes to evaluate committee effectiveness."

It is unclear when the committee was established and whether it continues to meet. The Dietary Services Director did not mention the existence of a committee when speaking with DRA in November of 2023 and specifically indicated that she was tasked with most of the goals now attributed to this committee. In April of 2025 the CHDC Superintendent stated that they have had the committee for "at least a couple of years." Based on sign-in sheet documentation provided to DRA, the Weight Committee met monthly from April-November of 2024. DRA was not provided with any records indicating that the Weight Committee met prior to April 2024 or after December 2024.[27] This gap in documentation creates uncertainty about when the committee was established and whether the committee has continued to meet.[28]

No meeting minutes are kept for the Weight Committee. According to the facility Superintendent, "Any issues or recommendations that are discussed in the meetings are provided to the residents' IDT [Interdisciplinary Team]." Furthermore, "Any actions are taken by the residents' physicians and Team."

Without written records, there is no clear way to verify what issues were discussed, what decisions were made, or what recommendations were proposed by the committee. Therefore, it is impossible to determine the effectiveness of the committee's work or track if interventions are implemented in a timely, appropriate manner. The lack of documentation also makes the mechanism by which issues and recommendations are relayed to the IDT unclear. DRA has not seen any records that indicate clinical decisions were influenced or recommended by the Weight Committee.

[27] Through the date of the request in May of 2025.

[28] In the past, CHDC has provided incomplete records to DRA, which was confirmed after follow-up by DRA. Under federal law, the facility is obligated to produce requested records upon appropriate request from DRA.

Ideally, the Weight Committee would track the date and time of the meeting, names of attendees, residents discussed, issues identified, recommendations made, assigned responsibilities, and a timeline for follow-up. The minutes could then be shared with the residents' IDT and other relevant staff depending on the recommendations made. Currently, the Weight Committee only records the date of meetings and attendees on sign-in sheets.[29]

Conway Human Development Center Weight Committee

CHDC Weight Committee
Purpose: The purpose of the Weight Committee is to monitor, review, and address significant changes in residents' weights in order to support optimal health, nutrition, and overall well-being. The committee ensures timely identification and intervention for weight changes that may indicate medical, nutritional, or psychosocial concerns.

Meetings:
The CHDC Weight Committee meets monthly and is chaired by our Registered Dietician.

Weight Committee Composition:
CHDC Registered Dietician
Team RNs
Clinical Speech Pathologists
QA APRN
Nurse Practitioner or designee

Goal:

- Identify residents with a weight loss or gain of **greater than 5% within 30 days** (or per facility protocol).
- Flag any trends or patterns in weight fluctuations.
- Recommend dietary modifications, medical evaluations, therapeutic interventions, or psychosocial support as needed.
- Monitor the effectiveness of interventions at subsequent meetings.

Continuous Improvement Plan:

- Identify systemic or facility-wide issues that may affect resident weights.
- Recommend staff training, menu adjustments, or policy updates as needed.
- Track outcomes to evaluate committee effectiveness.

[29] This information is based on the facility's response to a records request by DRA in April 2025. When DRA requested the meeting minutes and any documentation of outcome tracking used to evaluate the Weight Committee's effectiveness, the facility provided DRA with Weight Loss Committee sign-in sheets and confirmed that no minutes are taken at meetings.

Case Summaries

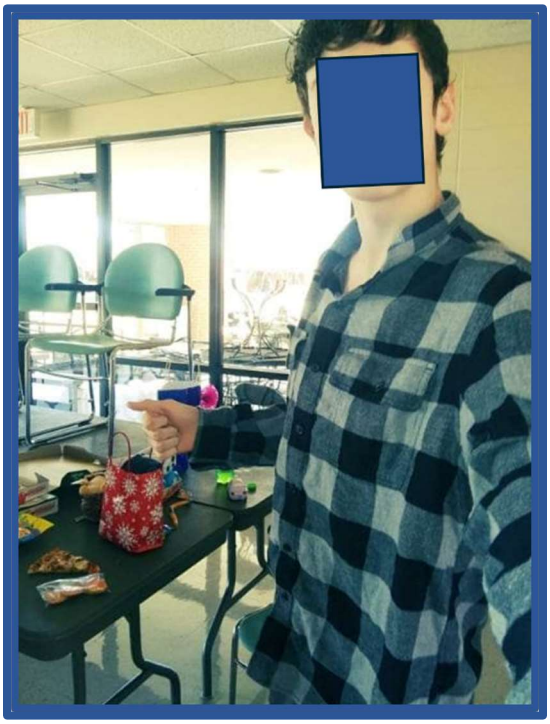
The issues noted above have real and serious consequences for the residents at CHDC. Below, four cases of malnutrition at CHDC that occurred between November 2023 to November 2025 and were identified and investigated by DRA are detailed. All four residents experienced significant, and in some cases severe, weight loss that was either ignored, insufficiently addressed, or responded to only after hospitalization. In our review, we found the following themes:

- Clinical signs such as emaciation and dangerously low BMIs were documented without appropriate or timely intervention.
- Residents received diet textures or supplements that conflicted with medical recommendations.
- Diet Orders were outdated, not implemented, or incorrectly documented.
- Staff frequently failed to follow through on external medical recommendations (e.g., from hospitals or specialists), often without clear documentation or clinical justification.
- DRA frequently raised valid concerns that were met with inaction or superficial responses. Despite substantiated reports of neglect or error, oversight bodies failed to cite deficiencies or drive corrective actions.

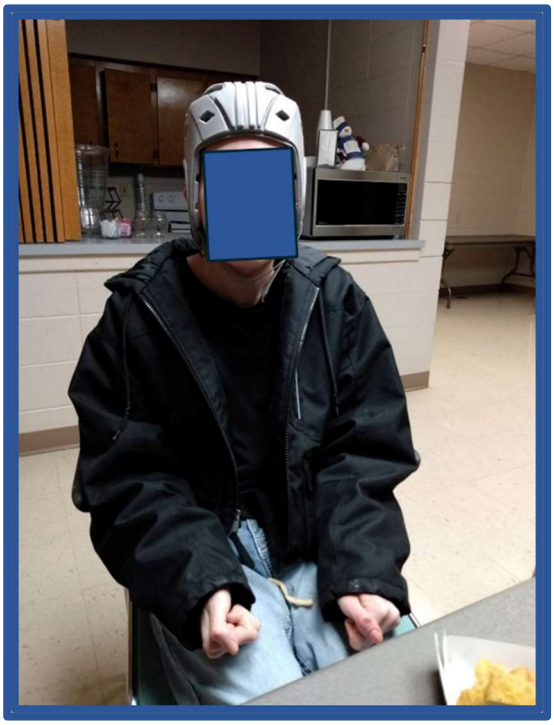
Resident 1

Within 10 months of moving from a children's cottage to an adult's cottage at the facility, Resident 1 experienced extreme weight loss and a decline in function requiring hospitalization and the use of a wheelchair, despite Resident 1's previous ability to walk without assistance.

The resident's unintentional weight loss, which was evident as early as January 2023, went largely unaddressed until the situation escalated dramatically, despite multiple missed appointments, missed follow-ups, and inconsistent dietary interventions. The delay in updating Resident 1's diet order and the failure to properly implement changes in nutritional supplements like ProStat further illustrate the inadequate response to the resident's declining health. In addition, there is a striking lack of coordination and communication between staff members, departments, and medical practitioners. For example, despite clear documentation of weight loss and other concerning symptoms, the facility failed to address these red flags promptly, even continuing to prescribe ineffective nutritional supplements well after they had been discontinued. The persistence of outdated and incomplete medical orders, such as the failure to update the resident's Diet Sheet post-hospitalization, also demonstrates systemic breakdowns in administrative practices. The facility's disregard for Resident 1's physical condition is most evident in its handling of the resident's pressure wounds and general malnutrition. Rather than taking immediate and appropriate action to address the worsening nutritional status and wounds, there was a pattern of inaction or delayed intervention, even as the resident's BMI dropped to dangerously low levels.



Resident 1 pictured in a black and white flannel in the fall of 2020. He appears to be at a healthy weight.



Resident 1 pictured in December 2022 in a black coat and white helmet eating French fries.

Resident 1 pictured in January 2023

Resident 1 pictured October 2023

The above photographs of Resident 1 were included in the report in order to show the resident's deterioration and draw awareness to the seriousness of what occurred. It is not possible to truly capture how emaciated this resident had become in words alone. This resident's parent provided 3 of these photos and gave DRA permission to publish them however, the resident reached the age of majority while at CHDC and formal legal guardianship has not yet been established. Resident 1 is not able to provide consent. After reviewing a draft of this report DHS threatened to report DRA and our staff to state and federal agencies for what they believe to be civil and criminal violations related to photographing individuals in long term care facilities, if we included photos in the published report.

January

Weight in January.

Resident 1 was seen by Arkansas Children's Hospital (ACH) Gastroenterology (GI) for unintentional weight loss of nearly 20 lbs.[30] No cause for the weight loss was identified during the visit. Follow up with GI in 6 months was recommended.

3/23 - 4/23 - Intake logs for March and April documented that Resident 1 received all supplements, received seconds every meal, ate all of his food at each meal, and had 16 oz of fluid at each meal and snack.

12 Birch	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	3·12-23			3·13-23			3·14-23			3·15-23			3·16-23			3·17-23			3·18-23		
	B	L	S	B	L	S	B	L	S	B	L	S	B	L	S	B	L	S	B	L	S
[redacted]																					
2nds	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ProStat AWC	✓	✓	X	✓	✓	X	✓	✓	X	✓	✓	X	✓	✓	X	✓	✓	X	✓	✓	X
Fiber Stat w/ 8oz water	X	✓	X	X	✓	X	X	✓	X	X	✓	X	X	✓	X	X	✓	X	X	✓	X
Ensure Plus	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amount Meal Eaten	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Amount Fluid Drank	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Staff Initials	KS	KS	DG	JC	JC	DG	[redacted]	[redacted]	DG	[redacted]	[redacted]	DG	KS	TA	LS	[redacted]	TA	TA	JC	KS	MO

Food Intake Log for Resident 1 for 3/12-3/18 completed to indicate resident ate all food, indicated using the number 5, and received all supplements and seconds.

May

Weight recorded on 5/2.

5/17 – Resident 1 was observed by his assigned SLP at lunch for his annual Dysphagia Disorder Survey. The survey notes that "calorie supplements were added to this diet plan and strategies for staff to offer second helpings was added to his eating plan to promote weight gain."

5/25 – Annual Individual Program Plan (IPP) review meeting. IPP did not include any plans to address Resident 1's weight loss.[31] Under the "Nutrition" section of his IPP, it states, "weight of 120 pounds is 17.8 pounds more than this time last year." While true, based on weights recorded by CHDC, this statement **overlooks the fact that he had begun to lose weight again and had lost 21 lbs. in the 3 months prior to the review**.[32] "Routine gastronomy feedings, routine gastronomy care (treatments, changes, venting)" is listed under "Nursing Interventions" on his IPP despite Resident not having a G-tube or PEG tube at the time.[33]

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[30] Although the hospital records state that he was seen because he had "lost nearly 20 lbs.," CHDC's records indicate he gained approximately 36 lbs. in the 8 months prior to the appointment. A weight of 102.2 lbs. is noted in May of 2022.
[31] The 01/13/23 ACH GI visit is listed but for findings states "Management pending results. Follow up in 6 months."
[32] It goes on to state, "BMI is 16.1, placing him at less than the first percentile of BMI-for-age and indicating he is underweight."
[33] Although this section uses vague, boilerplate language, it does vary slightly between residents, although not necessarily in ways that make it more specific to the individual resident. A DRA client from the same period that *does* have a PEG tube, *does not* have related interventions listed in their IPP.

June

6/28 – After Resident 1 refused his nutritional supplement, ProStat, multiple times in June [34], it was ordered to be discontinued by one of the facility's nurse practitioners. The order also stated, "Please eval diet for possible [changes] to replace nutrition provided by ProStat."

July

7/13 – 6 months since Resident 1's ACH GI appointment. There was no indication that a follow-up appointment was scheduled as recommended by the hospital, nor was any reason for a follow-up to not be scheduled noted.

7/24 – A new Diet Order was created in response to the order from the practitioner on 6/28, **nearly a month prior**. ProStat, which had been ordered to be discontinued, was still listed as a nutritional supplement.

Note – **Between July and August, Resident 1 lost an additional 14.2 lbs., lowering his BMI to 14.4.** Despite this dramatic weight loss, Food Intake Logs for the month of July documented that Resident 1 consumed all his food and supplements and accepted seconds at every meal, with a single exception in which he was documented as having eaten ¾ of his meal.

Weight recorded on 8/3.

Note – According to the August Food Intake Logs, Resident 1 consumed all his meals and supplements 92% of the time. He consumed ¾ of his meals and supplements the other 8% of the time. He also accepted seconds at 100% of meals.

August

8/31– Facility dietician recommended that Boost be added to Resident 1's diet as a nutritional supplement. However, "high calorie supplement with meals and snacks (Ensure Plus, Boost Breeze, or Boost Kids Essentials)" had already been part of Resident 1's Diet Order since 1/31/23. **She also inquired about placing Resident 1 on an appetite stimulant, seemingly unaware that he had been taking Megace (megestrol acetate) for over year.**[35] The nurse practitioner ordered an increase in Megace following the dietician's recommendations.

The living unit staff reportedly began working on identifying alternate food choices for meals.[36]

[34] June 2023 Practitioner Progress notes.
[35] Megace is an appetite stimulant that can be used to aid in weight gain following significant weight loss.
[36] 8/30/23 Nutrition Summary, 8/31/23 Practitioner Progress Note

September

9/5 – A CHDC nurse documented that Resident 1 appeared "well-nourished."[37] The resident remained at a very low weight for his height.[38]

9/7 – Megace was ordered to be discontinued and replaced with Marinol.[39]

9/8 – Resident 1 refused his ProStat and Boost supplements.[40]

9/9 – Resident 1 was switched from Megace to Marinol, a medication that has been approved by the FDA for chemotherapy-induced nausea and vomiting and weight loss associated with AIDS.[41]

9/11 – It was again noted that the resident refused his supplements despite the RN stating that she had "tried all things but once [resident] knows we put ProStat in pickle juice, V8, Boost, [illegible] [resident] refuses."

On this note, the nurse practitioner wrote, "ProStat was [discontinued] on 06/28/23, but inadvertently continued per diet order on 06/29/23."

9/13 – **Diet Order was finally corrected to reflect discontinuation of ProStat order on 6/28/23.** However, Nutrition Summaries continued to indicate the resident was receiving ProStat through at least October.

9/19 – The resident refused to drink his Boost supplement.[42] He appeared unwell this day, lying in bed all morning.[43]

9/20 – A pressure wound was noted to Resident 1's hip, with nursing staff noting, **"[Resident] is very underweight causing pressure ulcer now open…**" Just four months earlier, in May he was assessed as at low risk for skin integrity issues.[44]

On this date, weekly weights were ordered.[45]

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[37] 9/5/23 CHDC Nursing Physical Assessment
[38] An online BMI visualizer that adjusts a figure of a human body based on entered heights and weights does not allow for this resident's height of 6 feet and weight of 107.6 lbs. https://www.bmivisualizer.com/
[39] 9/7/23 Practitioner Progress Note
[40] 9/8/23 Practitioner Progress Note
[41] CHDC Medication Sheet
[42] 9/19/23 Practitioner Progress Note
[43] 9/19/23 Practitioner Progress Note (#2)
[44] CHDC Risk Assessment for Skin Integrity Issues
[45] When weekly weights are ordered, the resident will be weighed, and the weight should be documented every week. A specific day or time of day that the weights are to be taken each week is not indicated.

October

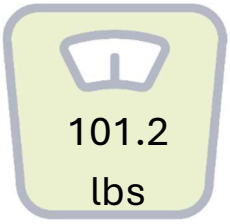
10/3/23 – Resident 1 was experiencing dark urine and refusing "almost every drink that isn't tomato juice."[46] According to Food Intake Logs, Resident 1 was drinking 16 oz of fluid at every meal and every snack every day in September. For the entire first week of October, Food Intake Logs indicated that Resident 1 drank 24 oz of fluid for every meal and 16 oz for every snack.

10/4 – Assessed in the CHDC Clinic for elevated heart rate. The nurse practitioner notes that she "would like [a] GI consult, if guardian agrees."

10/5 – Labs revealed that the resident had an elevated TSH level. He was ordered to be scheduled for an endocrinology appointment for a diagnosis of subclinical hypothyroidism.[47] [48]

Resident 1's food preferences were identified during a Special Staffing meeting. His Nutrition Summary indicated that the living unit social worker planned to purchase the preferred foods discussed so they could be offered as alternatives.

10/6 – **The dietician recommended allergy testing be performed to "confirm [Resident 1's] intolerance to milk," despite this testing having already been performed 3 months earlier and confirming that Resident 1 did not have a milk intolerance.** The dietician also recommended the placement of a feeding tube for nutritional supplementation.[49] Food Intake Logs indicate that Resident 1 ate ½ to ¾ of his meals from 10/1/23 to 10/4/23, but ate all of his meals on 10/5/23, 10/6/23, and 10/7/23.



Weight recorded on 10/10.

10/8 – Living unit staff reported to nursing that **Resident 1 had fallen several times while in the shower and hit his head**.[50] A Marks Report noted bruising to both his lower legs, left shoulder, and back.

10/9 – **Resident 1 fell and hit his face on a "laundry can,"** requiring an evaluation for a possible nasal fracture.[51]

10/11 – **A wound "with fat layer exposure"** was noted on Resident 1's hip. This note, written by a facility nurse, also describes Resident 1 as "**emaciated**."[52] A 3-day calorie count was ordered.[53]

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[46] Practitioner Progress Notes and Orders
[47] 10/5/23 Practitioner Progress Note
[48] 10/5/23 Practitioner Progress Note
[49] 10/6/23 Practitioner Progress Notes and Orders
[50] CHDC Neurological Record
[51] CHDC Neurological Record
[52] The Merriam-Webster Dictionary defines emaciated as, "very thin and feeble especially from lack of nutrition or illness (Merriam-Webster.com/dictionary/emaciated. Accessed 30 Oct. 2025.)"
[53] 10/11/23 Practitioner Progress Notes and Orders

10/16 – Another hip wound was discovered, with the nurse stating, "**These wounds are not likely to improve due to nutrition state**." Nursing staff also wrote that his 3-day calorie count requested on 10/11/23 had yet to be received.

10/18 – The nurse practitioner cancels Resident 1's evaluation for a PEG tube placement and orders a GI evaluation "for unexplained weight loss." Labs are also ordered.[54]

10/19– An appointment with endocrinology for a diagnosis of subclinical hypothyroidism was again ordered to be scheduled.[55]

Practitioner Progress Notes document the resident being offered numerous alternative meal options for the first time. These options included chicken nuggets, pizza, carrots, lima beans, Salisbury steak, waffles, Fritos, and rolls. Resident 1 ate 2 slices of pizza and chips and drank 2 cans of apple juice.

Weight recorded on 10/24.

10/24 –The psychiatric APRN noted, "client was lying in a recliner with eyes open and blank stare. His breathing was shallow but improved when tactile stimulation was applied."[56] The nurse supervisor was notified and the resident was brought to the facility's clinic. He was transported in a wheelchair, despite being ambulatory at baseline, due to the level lethargy he was experiencing. Staff present with Resident 1 in the clinic stated that Resident 1's behavior was normal.[57]

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[54] 10/18/23 Practitioner Progress Notes and Orders, After DHS reviewed a draft of this report and provided feedback, they stated "*entry from 10/18 is misleading and has additional context. There is a second progress note with further explanation that was not mentioned and reports that Eval for PEG was canceled because Dr. Landberg, GI doesn't do tube evals on clients without a guardian. Indication for appointment had to be changed to "unexplained weight loss" for patient to be seen by the physician*." DRA received three Progress Notes for 10/18, two list med refusal and do appear to say "see other PN." The third also lists med refusal and has a note that states "please cancel eval for PEG tube placement and schedule GI eval for unexplained weight loss." That note gives no indication that additional information is located a separate note. It is possible the note DHS is referencing exists and was not provided to DRA, despite our request for *all* Progress Notes. It is also possible, but unlikely, that it was provided and has been overlooked. DRA often receives records from this facility in an extremely disorganized manner. For example, the three notes from a single day referenced here were provided to DRA as pages 4, 6, and 34 of a 35-page file, interspersed between other dates ranging from 8/7- 10/24. One of the notes was also provided as part of a separate file of equally disorganized reports.

[55] 10/19/23 Practitioner Progress Note

[56] Observation on the unit made during psych APRN's periodic reviews. According to the CHDC Psychiatry Notes he had not been directly observed for over 10 months. He was "staffed with BHA and unit staff" without resident attending clinic in February, April, May, and August. In two of those months his medications were increased.

[57] After DHS reviewed a draft of this report and provided feedback, they stated "*entry from 10/24 is incorrect. The psychiatric APRN did not evaluate the resident, the note was written and signed by medical APRN. This is a separate person/position*." DRA reviewed and included information from both medical and psych APRN notes. A CHDC Psychiatry Note dated 10/24 and signed by an APRN, who is also listed on the note as a "Consulting Psychiatrist" includes a "Pertinent Mental Status Examination" section that reads "Client did not attend clinic today but was observed in the unit" and goes on to document the

The nurse practitioner noted that Resident 1 had an appointment with GI scheduled on 10/30/23, but that "no procedures could be done as [resident] has no guardian."[58]

Psychiatry Note states resident "recently" began refusing meals or "eating very little of what is served." Observation Report notes that Resident 1 refused breakfast and alternatives.

The Practitioner Progress note for this date documents Resident 1's weight as 97 lbs., despite weighing 101.2 the week prior. **The nurse practitioner noted that she was awaiting a response from a CHDC physician to admit Resident 1 to the hospital. He was admitted to the hospital on 10/26.**[59]

10/30 – Resident 1 had a feeding tube placed during his hospital admission.

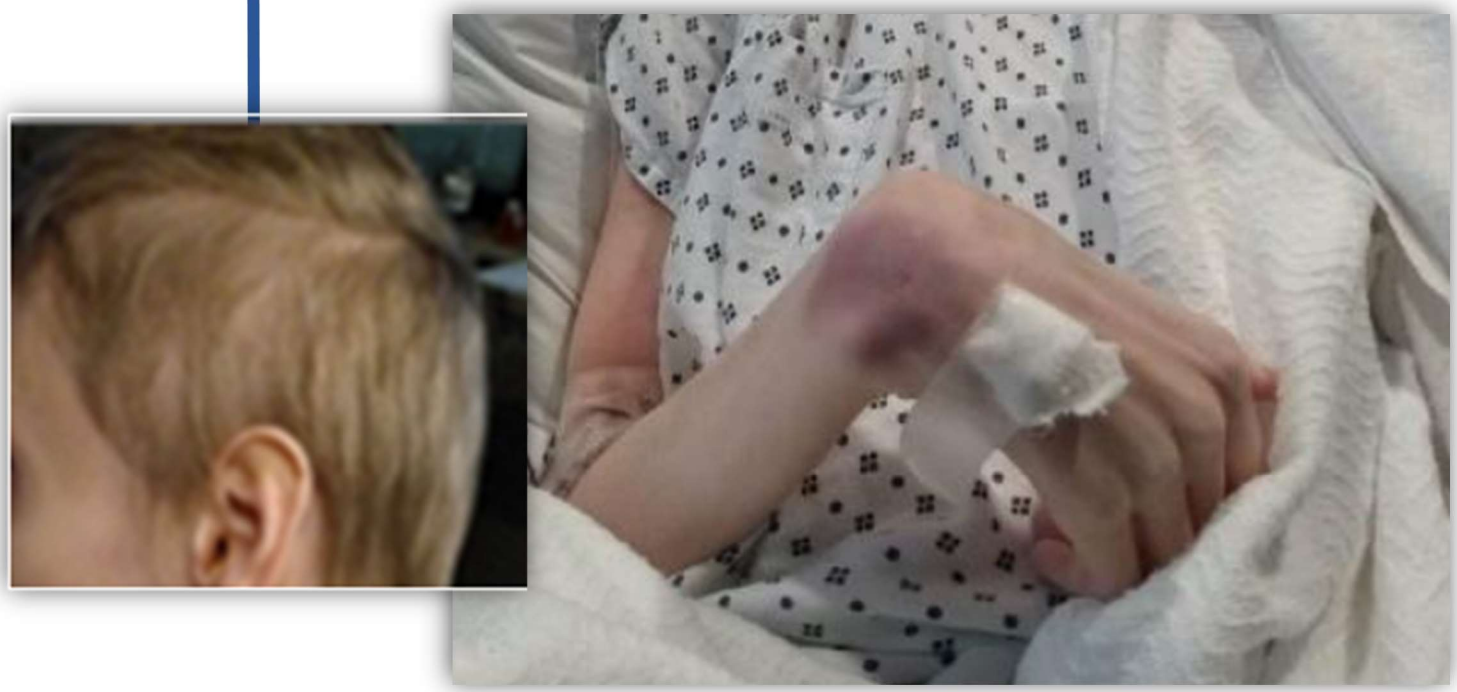

Photo 1 shows the thinning that occurred to Resident 1's hair. Photo 2 shows Resident 1's right arm and hand during the time he was admitted to the hospital.

observations included in the entry in the timeline above. The "correction" provided by DHS indicates the Psychiatric APRN falsely documented this observation in her records.

[58] Nurse Practitioner Note signed by Medical APRN

[59] After DHS reviewed a draft of this report and provided feedback, they stated in part that "*patient was admitted to the hospital that day by Dr. Woodard per GI recommendation for PEG placement. The way this is currently documented in the report is misleading*." He was in fact not admitted that day. That he was admitted two days later, on 10/26, was added.

November

11/1 – DRA visited Resident 1 at the hospital after receiving an allegation of neglect. Resident 1 was extremely thin with pronounced bones and thin limbs. Resident 1 was observed to be eating pizza without issue during this visit. Later that day he was discharged from the hospital back to CHDC, where he remained in the CHDC infirmary until 11/16.[60]

91 lbs.

Weight recorded on 11/01

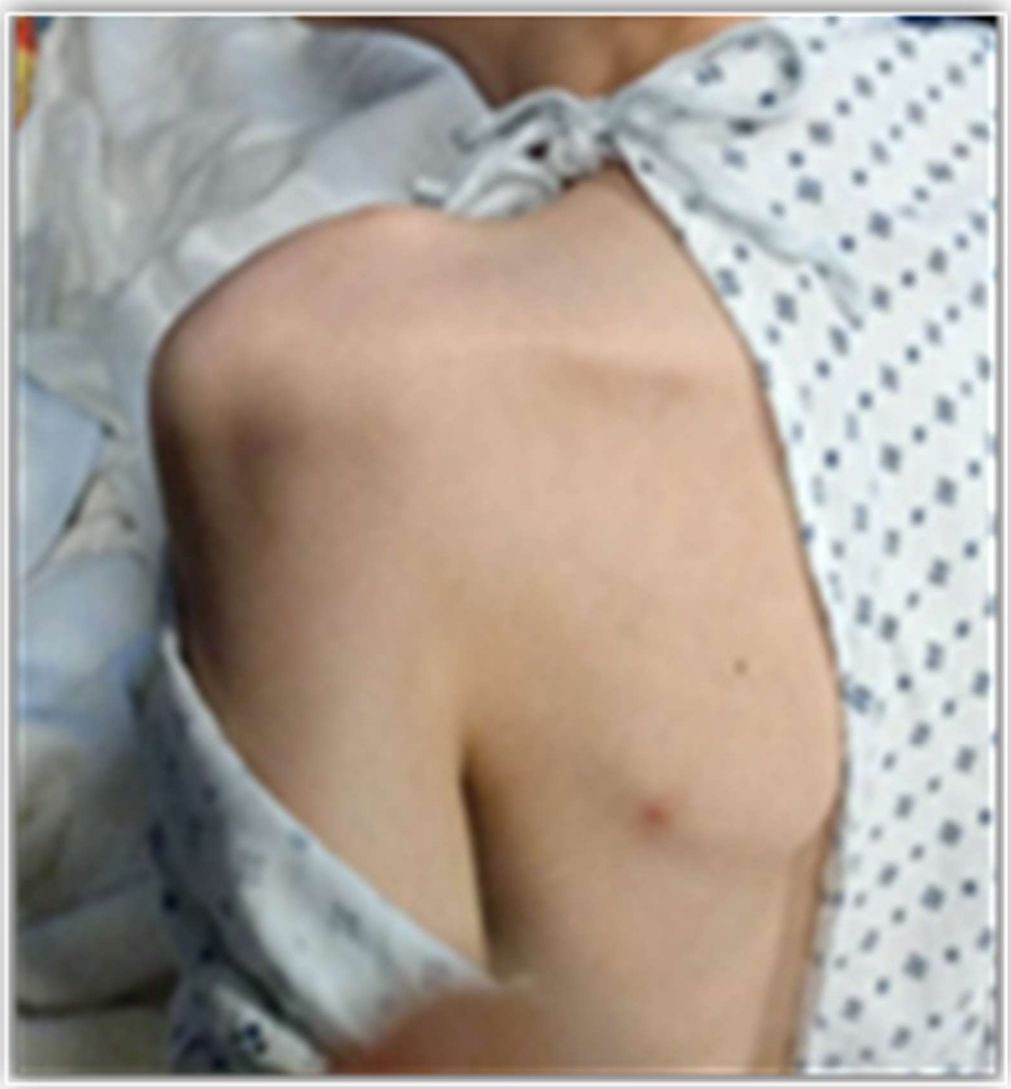

Photo shows Resident 1's left shoulder and back in an emaciated state.

[60] After DHS reviewed this report and provided feedback, they asked that it be noted that the resident weighed 103 lbs. when discharged from the CHDC infirmary on 11/16. No documentation was provided at that time or previously that would allow DRA to confirm this assertion. We can however confirm that based on CHDC records this resident did continue to gain weight throughout the subsequent months.

> **11/3** – At the request of the guardian, he was evaluated at ACH for weight loss. **ACH noted that, since Resident 1's January 2023 visit at the GI Clinic, Resident 1 had lost about 44 lbs.** A weight loss of about 20 lbs. had already occurred at the time of the visit in January.[61]
>
> **11/20** – DRA observed Resident 1's mealtime at CHDC following his hospitalization. Resident 1 was not provided with the correct adaptive eating equipment, a high-sided divided plate, which made it difficult for Resident 1 to keep the potato salad on the tray while attempting to scoop it up. This issue was brought to the attention of the ROM during the meal. Resident 1's plate was never exchanged for the correct plate. Most concerning, **Resident 1's Eating Plan had never been placed in the cottage, despite the fact that he had moved to the home 10 months prior**. Furthermore, Resident 1's most recently updated Diet Sheet had not been placed in the cottage. **Resident 1's Diet Sheet had been updated on 11/6/23, following his discharge from the hospital, but had not been replaced in the residence since his return.** The dietician was immediately notified of this issue by DRA.

A complaint detailing the issues observed by DRA during mealtime service at the facility was submitted to the Office of Long-Term Care (OLTC) on 12/4/23. OLTC failed to originally investigate the allegations. In April 2024, DRA received a letter from OLTC stating that the investigation had been completed and deficiencies were cited. However, DRA was unable to locate this OLTC survey through DHS's public database or through records requests. In May 2024, DRA was notified that OLTC investigated the 12/4/23 complaint and did not find "any violation of the regulations." [62]

Resident 1's hospital case manager was asked if Adult Protective Services (APS) had been contacted based on Resident 1's poor condition at the time of admission. The case manager confirmed that APS had not been contacted because the physician gets upset when APS is called.[63] APS was notified by DRA on 11/1/23, but informed that, since Resident 1 resides at a long-term care facility, the incident must be investigated by the Office of Long-Term Care (OLTC). While it is true that the OLTC is tasked with

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[61] After DHS reviewed a draft of this report and provided feedback, they stated, "*It would be important to note that the Resident was evaluated at Arkansas Children's Hospital (ACH) ER per the guardian's request, and returned to CHDC infirmary four hours later. No new treatment was recommended by ACH after the evaluation*."

[62] When this issue was discussed with DPSQA on 8/1/2024, officials stated that OLTC may review information sent by DRA to "drive" their investigation, but they may not use the information provided to them to cite deficiencies. No clear reason was given as to why the complaint was not originally investigated by OLTC.

[63] A draft of this report referred to this physician as a "CHDC physician." After DHS reviewed the draft of this report and provided feedback, they stated, "*Please clarify that the "CHDC physician" mentioned was acting in his capacity as a hospital employee for this allegation and not as a contracted employee of CHDC. At the time, the provider was contracted with CHDC only to provide endocrinology services to a small group of residents. The provider mentioned is infrequently on campus and did not have ordering privileges at the center."* This physician is documented as having called the death of 8 CHDC residents that died at this hospital between 7/2023 and 05/2024.

investigating maltreatment investigations at long-term care facilities, they are unable to directly affect the circumstances of individual residents or assume custody of residents. APS, on the other hand, may assume custody of individuals above the age of 18 who have a "mental or physical impairment" or "lack the capacity to comprehend the nature and consequences of remaining in a situation that presents an imminent danger to his or her health or safety," they are unable to protect themselves from maltreatment, and there is convincing evidence that the adult requires placement.[64]

DRA continued to follow up with Resident 1 to monitor his recovery. With the placement of the feeding tube, Resident 1 gained weight and is now considered to be within a healthy weight range.

Overall, this case underscores the urgent need for better staff training, improved communication between departments, stronger oversight of medical and nutritional interventions, and a more transparent approach to addressing potential neglect and mistreatment within long-term care facilities.

[64] Arkansas Code §§ 9-20-101 — 9-20-124 (2024)

Resident 2

Resident 2 was transferred from a pediatric care facility to CHDC after aging out of the program. At the pediatric care facility, Resident 2 was fed during a 24-hour window by feeding tube. Upon admission to CHDC, Resident 2 was placed in the Infirmary. A Special Staff Meeting note for around the time of Resident 2's admission reads, "The Infirmary is working to get his feedings within a 12-hour window so he may move to [another cottage]. If he is unable to tolerate his feedings in this amount of time, a residence with 24-hour nursing will be required." Following his stay in the facility's infirmary, Resident 2 was placed in a residence without 24-hour nursing care, where he received feeds within a 10-hour daily window.[65] Despite the rationale not being documented in any of the records received by DRA, it is assumed that Resident 2 was not placed in a residence with 24-hour nursing care in an effort to place him with residents of similar abilities and that are also able to self-ambulate. Residents in the 24-hour nursing care unit are considered the most medically fragile patients at CHDC.

Resident 2's feeding formula was also changed upon admission to CHDC. The dietician changed Resident 2's formula from Kate Farms Peptide 1.5 to Vital 1.5. Resident 2's Individualized Program Plan (IPP), written shortly after his admission to CHDC, states, "Discussed resident with dietician [redacted] from [redacted]. She reports the resident has an intolerance of milk and egg products. Stated that he is on Kate Farms Peptide 1.5 plains…Reports of GI distress with allergens such as bloating, diarrhea and vomiting." Despite his IPP addressing an intolerance of milk, Resident 2 was switched from a dairy-free formula to a formula containing milk. However, Resident 2's milk intolerance was not completely ignored, as his Diet Order created the day following his admission lists him as having a milk allergy. Five months later, Resident 2's formula was changed back to Kate Farms Peptide 1.5 according to a Diet Order and Practitioner Progress Note written on this date. The dietician noted in the Practitioner Progress Note that, based on allergy testing results, Resident 2 should not have eggs, peanuts, or tree nuts, and that "Kate Farms Peptide is free of allergies." There is no mention of a milk allergy and subsequent Diet Orders do not list Resident 2 as having a milk allergy.

Resident 2 was noted several times to pull at his feeding tube and disconnect it, halting his feedings and losing formula. It is unknown how this was managed by the staff at his previous care facility, but it was noted that Resident 2 had been receiving his primary means of nutrition and hydration through his feeding tube for 18 years.

Six months following his admission to CHDC, Resident 2 was admitted to the facility's infirmary for low weight. According to Height & Weight logs, Resident 2 had lost 23.2 lbs. since his admission, going from a healthy BMI of 21.3 to an underweight BMI of 17.0. While in the infirmary, 24-hour feeds were resumed. Roughly a week and a half after his admission to the infirmary, Resident 2's interdisciplinary team (IDT) agreed with Resident 2's nurse practitioner to place him in a residence on campus that could support his need for a 24-hour feeding window.

[65] A Diet Order was written for Resident 2 following his Infirmary stay, listing his feeding window as 10 hours.

At a Special Staffing Meeting held roughly seven months following his admission to CHDC, it is noted that Resident 2's mother expressed concern for Resident 2's weight loss and encouraged CHDC staff to contact the pediatric care facility where Resident 2 previously received care to "ascertain his feeding information." However, as stated in his IPP dated seven months prior, the dietician had already spoken with Resident 2's dietician at the pediatric care facility.

Another Special Staffing Meeting was held roughly two weeks later. At this time, it was noted that Resident 2's feeding tube was recently changed from an unspecified gastric-jejunal (GJ) tube to a mickey button. A mickey button is a name-brand GJ tube, which is described as a "low-profile gastric tube" because it sits flush with the skin, while traditional GJ tubes extend outside of the body. It was also noted that Resident 2 had started to wear an abdominal binder, making it "more difficult to disconnect his feeding tube."

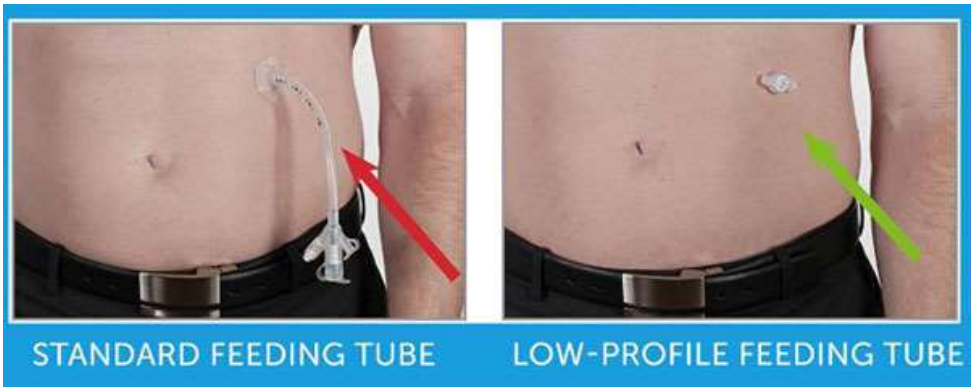

Figure 1: Photo courtesy of ALS Association.

Following his placement in a residence with 24-hour nursing services, Resident 2 returned to a healthy weight. However, this case reveals several systemic failures that contributed to Resident 2's weight loss. Despite clear documentation of a milk intolerance, CHDC staff changed Resident 2's feeding formula from a dairy-free option to one containing milk, contradicting both his IPP and Diet Order, which listed a milk allergy. This decision reflects a failure to respect documented medical history and dietary needs, resulting in unnecessary risk.

Additionally, Resident 2 was placed in a residence without 24-hour nursing care despite the known need for extended feeding support, initially requiring a 24-hour window and later restricted to a 10-hour window. If CHDC initially avoided placing Resident 2 in a residence with 24-hour nursing care because the residents in this home had higher support needs, this decision reflects a prioritization of perceived social or behavioral compatibility over medical necessity. While matching residents based on functioning level can be important for quality of life and care dynamics, doing so at the expense of critical health needs—such as requiring a 24-hour feeding window and nursing oversight—represents a systemic failure in care planning.

Finally, the delayed response to Resident 2's ongoing weight loss demonstrates poor communication and a disregard for early warnings. Although prior communication with the former care facility was documented, staff still considered re-engaging that facility seven months later, indicating either poor recordkeeping or fragmented internal communication.

Resident 3

Five months after his admission to CHDC, Resident 3 was sent to the ER for lethargy, hypothermia, and hypotension. After an evaluation at the local hospital, Resident 3 was transferred to a pediatric hospital, where he was admitted with a diagnosis of urosepsis.[66] During his 15-day admission, Resident 3 received treatment for severe malnutrition.[67]

Hospital records indicate that his BMI at the time was 13.7, in contrast to his BMI of 17.5 [68] at the time of his admission to CHDC, and he appeared "undernourished" and "very thin." During his hospital admission, Genetics confirmed that there was no concern for a mitochondrial disorder, which could cause weight loss. To address his nutritional status and promote weight gain, hospital staff increased Resident 3's Boost supplementation to four times daily. Resident 3 had been receiving two nutritional supplements per day at CHDC.[69]

Within his 15-day stay, Resident 3 had gained 10 lbs. Upon discharge, the hospital dietician noted that Resident 3 had been eating 100% of most meals and drinking his Boosts as ordered. Pediatrics noted, "Concern that facility has not been meeting dietary requirements to thrive."

Hospital records recorded Resident 3's weight as 97.9 lbs. CHDC Height & Weight logs listed his weight as 125 lbs. just two days prior - a 27.1 lb. difference. The hospital dietician addressed the weight discrepancy with CHDC's dietician, who stated that staff are trained to weigh Resident 3 in his wheelchair, weigh the chair separately, and then subtract the weight of the chair each time. She hypothesized that staff had failed to subtract the weight of the wheelchair but was unable to tell hospital staff how much Resident 3's wheelchair weighed. She also stated that she would check the facility's scales for accuracy.

[66] Urosepsis is a type of sepsis, a severe, life-threatening infection characterized by inflammation throughout the body that could lead to organ failure, caused by a urinary tract infection.
[67] The hospital rated Resident 3's "Malnutrition Severity" as "Severe less than –3."
[68] This number was obtained from the resident's IPP.
[69] Reports received by the hospital dietician indicated that Resident 3 received 3 cartons of Boost per day, however resident's CHDC Nutrition Summary stated he was receiving 2 nutritional supplements per day.

Resident's Dysphagia Disorder Survey and Dysphagia Management Staging Scale Test Form lists that the resident "eats independently." The CHDC Dysphagia Disorder Survey Narrative Summary from the same date notes that "[resident] is fed by a caregiver due to physical limitations" and an "inability to feed self."

DRA shared our concerns regarding Resident 3's hospitalization for urosepsis and malnutrition with DDS officials. This report was shared with the facility, which began investigating to determine if medical neglect had occurred at their facility. Ultimately, the facility unsubstantiated themselves for maltreatment, stating that it was "determined that proper care was provided by staff and special measures were implemented as necessary…" However, if the facility staff had properly cared for the resident and issued all changes as necessary, as was the position of CHDC, Resident 3 would likely not have required a hospital admission for malnutrition.

The special measures listed by the facility as having been implemented as necessary included:

> **"1) The Dietician ordered an increase in caloric intake and supplement increase at all meals and snack times."**
>
> > ***The facility did not update Resident 3's Diet Order to reflect the recommendation made by the hospital dietician at the time of discharge to increase Boost to four cartons per day until 3 weeks after his discharge from the hospital.***
>
> **"2) [Resident's] diet was changed to a chopped diet due to not chewing food well."**
>
> > ***Resident received a chopped diet for at least 3.5 months prior to his 15-day hospital admission.***[70]
>
> **"3) [Resident] is being weighed weekly in the CHDC Clinic for a consistent weight reading."**
>
> > ***Over a month after his discharge from the hospital and the same day DRA's concerns were reported to the facility, the dietician documented that Resident 3 would be weighed weekly in the clinic for four weeks, or until his weight stabilized.***[71] ***The same note also reads, "Weight and height discrepancies" and "possible weight loss," documenting resident's weight for that month as 112.6 lbs. It also noted his height for the month was recorded as 70 inches, but his height at admission was 72 inches. A separate note for the same day indicates a physical was performed and documents the resident's weight as 109 lbs.***

In summary, according to the incident report, no changes were made by the facility in response to DRA's complaint beyond what was already implemented into Resident 3's plan. Due to the lack of accountability taken by CHDC, DRA submitted an OLTC complaint on 8/22/23 in hopes that the oversight agency would order the facility to perform corrective actions to prevent further incidents. However, while

[70] CHDC IPP, 02/07/23 CHDC Dysphagia Disorder Survey Narrative Summary
[71] Practitioner Progress Note

OLTC did cite deficiencies during their complaint survey, none of these were related to nutritional services.

Inconsistencies between reported and documented nutritional supplementation, the failure of the facility to update his Diet Order to reflect hospital recommendations until three weeks post-discharge, and the inability of staff to follow basic procedures, such as accurately weighing residents, contributed to the decline of Resident 3. Concerns about weight and height discrepancies persisted even after discharge from the hospital, indicating ongoing monitoring failures.

Resident 4

Resident 4, aged 16-years old, was hospitalized for nearly a month for malnutrition and Depakote toxicity. Upon admission to the hospital, Resident 4 weighed 69.4 lbs. at an approximate height of 4 ft. 10 inches —a 14.3 lbs. difference from the weight documented by the hospital 4 months prior—with a BMI of 14.5. During his admission, Pediatrics speculated that the sedative effects of the psychiatric medications Resident 4 was taking upon admission to the hospital could have contributed to Resident 4's malnutrition, writing, "**The amounts of sedative medication the patient was on raises concerns for misuse of these medications for this patient leading to dangerous changes in his mentation and ability to eat…**" CHDC staff reported to Pediatrics that "they will often not feed him if he is sleepy."[72]

> **"On several occasions we have been told by facility caretakers that they will often not feed him if he is sleepy. Given his state of sedation and the amount of medications he was on that caused sedation, there is concern that he was overmedicated and subsequently not fed at his nutritional requirements because of his sedation."**
>
> ACH Records

[72] This information was obtained from Resident 4's hospital records from his admission for malnutrition. After reviewing this report DHS asked that the following note be included, "*Please note that regarding Resident 4 "oversedation" is not a medical diagnosis and was never listed on active problem/diagnosis list during hospital admission at Arkansas Children's Hospital*." "Altered mental status" was however listed as a diagnosis for this patient and his discharge instructions included "During this patient's hospital stay he was found to be encephalopathic secondary to Depakote associated toxicity. In addition he was found to be ***overly-sedated*** with a large polypharmacy burden of multiple CNS-sedating medications." This was followed by a recommendation to discontinue six of his medications and reduce the dosage of a seventh in order to "protect him from his potential self-harming behavior while also not overly-sedating him."

Pediatrics also voiced concern for Resident 4 receiving an inappropriate diet texture at CHDC based on speech evaluations performed at the hospital, stating, "During the study it was found that he was not safe for solid foods and had high risk of aspiration. During his hospital stay he was only cleared for puréed food and able to drink liquids. **This finding shows concern that patient was either [sic] eating dangerously at the outside facility.**"[73]

DRA monitored Resident 4's lunch at the facility shortly after his release from the hospital and observed Resident 4 being served a regular diet texture (taco salad). He, nor any of the other residents in the residence at the time, received nutritional supplements listed on their Diet Sheets. Additionally, Resident 4 was not offered second servings, as per his Diet Order and Diet Sheet. When DRA asked staff why Resident 4 was not offered second servings despite finishing his plate, they stated that he will vomit if he gets "too full." DRA asked how staff could tell when Resident 4, who is non-verbal, was full and they stated that he will begin to burp, shake his head, or push his tray away. DRA staff noted that Resident 4 had burped at the beginning of the meal but had not shaken his head or pushed his tray away. After this discussion, staff served Resident 4 dessert of a strawberry cake moistened with pears on top.

DRA promptly informed the dietician of the issues noted during this mealtime observation and voiced concerns about the mealtime service provided to Resident 4 considering his recent hospitalization for malnutrition. However, when DRA conducted a follow-up monitoring visit a week later to ensure that changes had been implemented, Resident 4 was again served a regular diet texture and not offered second servings. His meal consisted of full-sized, uncut green beans and a chicken-fried steak, which was manually cut into large bite-sized pieces by staff. Additionally, Resident 4 was not offered any dessert, which was ice cream. Following this observation, DRA went to the facility and spoke with Resident 4's primary care physician, social worker, and the facility's Assistant Superintendent regarding dietary services issues.[74]

DRA also notified the facility and DDS regarding concerns that Resident 4 had been prescribed a potentially unsafe diet texture. Specifically, DRA was concerned that Resident 4 was placed on a "chopped" diet upon returning to the facility, despite two hospital-based SLPs determining that he was only safe to consume pureed foods. CHDC, however, maintained their decision to implement a "chopped" diet based on the assessment and recommendation of the facility's SLP, rather than

[73] After DHS reviewed a draft of this report and provided feedback, they provided the following statement relevant to this issue, "*There is a misrepresentation of the speech evaluation while in hospital. There was no documented formal swallow study while he was in the hospital. Pureed diet was ordered on admission "per history". We could not find any documentation in hospital record of trialing him on a more advanced diet. He was evaluated again by speech upon return to CHDC and deemed safe for resuming his previous diet*." Neither the draft copy nor this final report indicated a formal swallow study was completed. What occurred, and what is reflected in this report, is that he was observed and evaluated by a Speech Language Pathologist multiple times during his 25 day admission and it was never deemed appropriate to trial him on a different diet or food texture, and he was able to "make steady weight gain and meet or exceed his daily caloric goals" on the prescribed diet during his admission.

[74] DRA staff attempted to speak with Resident 4's SLP on this day as well, but the Superintendent stated that DRA should email with questions.

following the hospital SLPs' recommendation for a pureed diet. In response to DRA's inquiry, CHDC explained that their "chopped" diet is "very close to what the hospital deems 'pureed.'" As noted in the Diet Textures section of this report, "chopped" and "pureed" diets are distinct in both preparation and consistency. If the two diets were equivalent, there would be no clinical need to differentiate between them.[75]

Resident 4 had experienced persistent low weight for an extended period prior to his hospitalization in late 2024. His medical history includes well-documented episodes of post-meal vomiting. However, during his hospital stay—where he was placed on a pureed diet—Resident 4 exhibited minimal vomiting and demonstrated steady weight gain.[76] When DRA inquired whether the resident's previous episodes of vomiting could have been related to receiving a diet texture inconsistent with the hospital's recommendation for pureed foods, the facility's primary care physician stated that she did not believe diet texture was a contributing factor. Approximately four months after discharge, Resident 4 was evaluated in the ER following a referral by a physician during a scheduled outpatient appointment. The referral was prompted by information from accompanying staff that Resident 4 had been experiencing consistent vomiting after meals for the preceding three weeks. The ED evaluation ruled out infection and identified moderate constipation, which was cited as the likely cause of his vomiting at that time.

The circumstances surrounding Resident 4's hospitalization and issues following his return to CHDC reveal multiple systemic failures in clinical oversight, interdepartmental communication, adherence to medical recommendations, and implementation of appropriate nutritional care protocols. Concerns raised by DRA and hospital physicians regarding inadequate feeding practices were either dismissed or insufficiently addressed.[77] These failures reflect broader deficiencies in care coordination, staff training, and quality assurance processes, placing Resident 4's health and safety at continued risk.

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[75] According to the IDDSI, a Level 4 Pureed diet consists of foods that are smooth, cohesive, and do not require chewing. In contrast, a Level 5 Minced & Moist (commonly referred to as "chopped") diet includes soft and moist food pieces that are 4 mm or smaller for adults and require minimal chewing. These levels are not interchangeable, and inappropriate texture can increase the risk of choking, aspiration, or inadequate nutritional intake. (Source: IDDSI Framework, www.iddsi.org)

[76] After DHS reviewed a draft of this report and provided feedback, they provided the following statement in response to the report stating the resident "exhibited minimal vomiting" during his hospital stay, "*regurgitation of food was listed as an active problem on diagnosis list. Subsequently, GERD medication was increased following a vomiting episode on 12/10/24. ACH GI was well-aware of this issue years prior to this hospital admission. Evaluation and management of this issue remains ongoing.*"

[77] CHDC administration was unwilling to admit that there was any issue with Resident 4's "chopped" diet texture following him being deemed safe only for pureed foods by the hospital in interactions with DRA. If the issues were identified internally, DRA was not privy to any changes implemented to ensure this resident was placed back on a pureed diet.

Recommendations

1. CHDC should employ two or more dieticians in addition to the Dietary Services Director.
2. CHDC should immediately begin long-term increased monitoring of mealtimes in the cottages.
    a. Dieticians and Speech Language Pathologists should regularly monitor mealtimes in the cottages to ensure meal plans are being correctly implemented.
    b. CHDC administration should review video footage of mealtime services on randomly selected dates to ensure staff are complying with residents' meal plans and correctly documenting food and liquid intake.
3. DDS should immediately consult with independent professionals to reform dietary practices at CHDC.
    a. Independent consultants should review facility definitions of diet textures, staff training, all current procedures, Quality Assurance Subcommittees, and the Weight Committee.
4. CHDC should meaningfully implement multidisciplinary committees, such as the Weight Committee.
    a. Meaningful implementation, at the very least, requires regularly taking meeting minutes that include the assignment of tasks, dates by which actions should be carried out, and scheduled review for any needed follow-up to ensure the individual issues with residents are addressed.
    b. A plan to track outcomes, identify systemic issues, and institute changes, as is listed on the current CHDC Weight Committee description, should be actually implemented.
5. CHDC should implement a policy in which only medical professionals, and not direct-care staff, can weigh or measure the heights of residents to avoid inaccurate measurements.
6. CHDC should immediately transition to electronic medical records (EMR).
7. Division of Provider Services and Quality Assurance within DHS should increase oversight.
    a. Increase knowledge base of investigators related to general investigative techniques and subject matter specific areas, such as meal service and diet plans.
    b. Expand timeframe on campus to investigate complaints, including monitoring during dinner or evening shifts.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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November 14, 2025

RE: Feedback on DRA report entitled "Malnourished: The Recurrence of Malnutrition at a Large, State-run Facility for Individuals with Intellectual and Developmental Disabilities"

Disability Rights Arkansas,

We appreciate the opportunity to respond to the report and share added context and information that should be included in the information presented. Please see our feedback below and request that the report be revised and/or our corrections be attached to this report prior to publication.

Pg. 4 Upon review of all deaths reported in the time frame indicated in the report, by CHDC, only five residents had a BMI that fell below normal range.

Pg. 27 entry from 10/18 is misleading and has additional context. There is a second progress note with further explanation that was not mentioned and reports that Eval for PEG was canceled because Dr. Landberg, GI doesn't do tube evals on clients without a guardian. Indication for appointment had to be changed to "unexplained weight loss" for patient to be seen by the physician.

Pg. 27 entry from 10/24 is incorrect. The psychiatric APRN did not evaluate the resident, the note was written and signed by medical APRN. This is a separate person/position.

Pg. 27 entry for 10/24/23 states that Resident 1 had appointment schedule with GI on 10/30, but that "no procedures could be done.." due to lack of guardianship. However, patient was admitted to the hospital that day by Dr. Woodard per GI recommendation for PEG placement. The way this is currently documented in the report is misleading.

Pg. 28 entry for 11/1/23 discusses the DRA visiting resident in hospital. The resident was discharged from Conway Regional Medical Center this day and admitted to the CHDC infirmary until 11/16/23 for tube feed titration. We would request clarification on this entry.

Pg. 28 entry for 11/3/23, It would be important to note that the Resident was evaluated at Arkansas Children's Hospital (ACH) ER per the guardian's request, and returned to CHDC infirmary four hours later. No new treatment was recommended by ACH after the evaluation.

Pg. 29- Please clarify that the "CHDC physician" mentioned was acting in his capacity as a hospital employee for this allegation and not an contracted employee of CHDC. At the time, the

provider was contracted with CHDC only to provide endocrinology services to a small group of residents. The provider mentioned is infrequently on campus and did not have ordering privileges at the center.

We would also like to note that the Resident's weight was 91.2 lbs. on admission to infirmary on 11/1/23, 103.0 lbs. on 11/16/23.

Pg. 34 – Please note that regarding Resident 4 "oversedation" is not a medical diagnosis and was never listed on active problem/diagnosis list during hospital admission at Arkansas Children's Hospital.

Report further goes on to state on page 35 that resident "exhibited minimal vomiting" during hospital stay, but regurgitation of food was listed as an active problem on diagnosis list. Subsequently, GERD medication was increased following a vomiting episode on 12/10/24. ACH GI was well-aware of this issue years prior to this hospital admission. Evaluation and management of this issue remains ongoing.

Pg. 35, paragraph 2 – There is a misrepresentation of the speech evaluation while in hospital. There was no documented formal swallow study while he was in the hospital. Pureed diet was ordered on admission "per history". We could not find any documentation in hospital record of trialing him on a more advanced diet. He was evaluated again by speech upon return to CHDC and deemed safe for resuming his previous diet.

Respectfully submitted,

Jennifer Brezee

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