



# The License to Mismanage:

## Investigating Utah's Troubled Long Term Care System

Protection & Advocacy in Utah





On January 26, 2022, Evergreen Place (“Evergreen”), a board and care home, was shut down by Salt Lake County. Local media coverage reported Evergreen was closed because the facility had been without heat during winter months, was covered in raw sewage, and had a severe bed bug infestation. However, closing Evergreen in the wake of deplorable conditions was not the end of the story for its residents.

Over the last year, the Disability Law Center conducted an in-depth investigation into the death of one of Evergreen’s former residents, Chien Nguyen, a person with severe and persistent mental illness. Information about the events discussed in this report are based on news reports, publicly available documents, interviews, visits, and records

gathered through the DLC’s Protection and Advocacy agency federal statutory authority. The events in the report are allegations and have been described to the best of the DLC’s ability based on the evidence available. Chien was failed by the state and its oversight system numerous times when he transferred from the inhumane conditions at Evergreen to another facility that had been cited for poor care where he died. Chien’s life mattered, and he is survived by his family who loves him deeply. His story is an egregious example of how the state of Utah’s licensing agency fails people with disabilities.

## The Disability Law Center

Every state has a Protection and Advocacy organization with a federal mandate to monitor conditions in settings that serve people with disabilities, investigate potential abuse and neglect of people with disabilities, inform people with disabilities about their rights, educate policy makers about the needs and rights of people with disabilities, and advocate to end rights violations, abuse, and neglect of people with disabilities. The Disability Law Center has been designated as Utah’s Protection and Advocacy System by the governor and has federal statutory authority to conduct this work.

## Long Term Care Facilities Oversight Authority

The Centers for Medicare & Medicaid Services (“CMS”) is the federal agency that regulates long term care facilities. Every state has a licensing agency that inspects and investigates private and state facilities for CMS. In Utah, the Division of Licensing and Background Checks (“DLBC” or “Licensing”) is the agency that inspects and surveys to license and certify long term care facilities and is housed within the Department of Health and Human Services (“DHHS”).<sup>1</sup>

The DLBC’s stated mission is to protect the dependent and vulnerable citizens of Utah. The standards used and the frequency of monitoring of these facilities is determined by state and federal law and is dependent on the type of facility. Usually, DLBC will send a “statement of deficiencies” to a facility if they are not meeting a federal requirement, to which a facility will respond with a “plan of correction.” If the deficiencies are not corrected, the state agency can take enforcement action against the license of the facility, levy fines and even recommend that a facility’s federal certification and funding be terminated. State licensing agencies that fail to ensure health and safety requirements are being followed by long-term care facilities can have their federal funding reduced by CMS.<sup>2</sup>

## Evergreen Place

Evergreen Place, located in Midvale, Utah, was an unlicensed board and care home housing 17 individuals with severe and persistent mental health disabilities. On January 26, 2022, Evergreen was shut down by Salt Lake County Law Enforcement and the Salt Lake County Health Department for deplorable living conditions, including a significant bed bug infestation, raw sewage leaking through the walls, and no heat in the wintertime. The boarding home operator charged residents between \$700 and \$1,400 per month in rent; when asked why some residents paid more, he said “some received more money from their pensions and were therefore charged more.”<sup>3</sup> At the time of the shutdown, residents had to be decontaminated by Utah Fire Authority Hazardous Materials Team’s Decontamination unit.

Complaints about Evergreen had been made over several years to state and local government agencies. Records demonstrate that state agencies were reluctant to act earlier because there was nowhere else for residents to go. As a New Choices Medicaid Waiver provider, Evergreen would have been subject to periodic certification visits by DOH. Internal messages state “when searching email I saw our exchange when they had to get a base level of cleanliness to get their provider agreement completed several years ago [...] each year we would give them a list of things they needed to fix.” “I get the sense that a lot of leeway was given in general as [the inspector] felt that if he failed IL [Independent Living] providers in their inspection, many NCW [New Choices Waiver] participants would be displaced who would not otherwise be able to afford room and board at any other facility. Not to say [the inspector] did anything unethical in his documentation or underreported. He just saw a lot of general cleanliness issues and outdated settings across the board.” “And



I would guarantee that when he was there 2 years ago that raw sewage was not present throughout the facility.”

At the time of the shutdown, state and local agencies were aware of problems at Evergreen. As documented in an affidavit by law enforcement, the owner of the boarding house said “he had applied for an assisted living license, but ‘due to some background issues’ never heard back from the state health department, so he opened his facility as a ‘group home’ instead.”<sup>4</sup> Internal records with the Utah Department of Human Services show (“DHS”) that in January of 2021 a West Valley City official and local police contacted a DHS licensing investigator with concerns about an unlicensed group home. The investigator contacted the owner of Evergreen in April of 2021 and instructed him to apply to be a Residential Support provider, noting that failure to do so would result in legal action by the state. The investigator contacted the owner again in May and reiterated that Evergreen must submit an application immediately or face a cease and desist notice. By May 21, 2021, the owner applied but it appears that there was no further action from the state until the next year when Evergreen was closed by the county.<sup>5</sup>

Prior to its closure, Evergreen had a pending license with the Department of Human Services, was an enrolled Medicaid provider and was a contracted New Choices Medicaid waiver provider with the Department of Health.<sup>6</sup> Evergreen also continues to be listed as a contract housing provider with Salt Lake County for people with mental health disabilities in their area mental health plan.<sup>7</sup> Communication obtained by the DLC between DOH and DHS staff regarding Evergreen demonstrates a lack of appropriate oversight. DOH staff state “we’re worried that they really had no oversight by any entity and instead relied on the residents for their income.” DHS staff



relate the following “Question from reporter: Is there a follow-through process on the part of OL to make sure a facility does what they’re supposed to do, or is it simply the honor system? [...] I don’t think he’s realizing that even with a license we would have been out there maybe once a year announced [...] Can I just say ‘It’s on the honor system. We encourage any member of the public, or organization placing an individual in a care facility to check for proper licensure.’ [...] we aren’t a health enforcement agency [...] Maybe add your language that we aren’t a health enforcement agency? [...] It is not standard of practice that we let facilities operate without a license. [...] They were notified they needed to have a license. [...] But do we have a follow through process? [...] not in rule really, but we should have.” After Evergreen was shut down, DHS created a new policy regarding unlicensed facilities “We discussed this situation in admin this am and will be issuing a guideline for how to handle unlicensed programs moving forward. Essentially once we determine they require licensure, we (investigator/licensor) will issue an immediate cease and desist notice and give 30 days to come into compliance. Any unlicensed programs that come to you need to be coordinated with the investigator or licensor to ensure the 30-day time frame is met or we proceed with litigation.”<sup>8</sup>

# Chien Nguyen

Chien Nguyen lived at Evergreen for a year before it was shut down in 2022.<sup>9</sup> Chien was 48 years old with a long history of mental health disabilities and had previously been institutionalized at the Utah State Hospital.<sup>10</sup> Medical records indicate that he was diagnosed with Schizophrenia and Schizoaffective disorder and was consistently experiencing suicidal ideation.<sup>11</sup> Chien was also an immigrant who primarily spoke Vietnamese. He was close to his brother Nick who would frequently visit. Nick observed that Chien did not seem to be well taken care of, did not always receive his medication and often did not have food.

Chien received Medicaid services and treatment through professionals from Valley Behavioral Health (a provider contracted with Optum/Salt Lake County to provide mental health services). Chien had an Assertive Community Treatment team (ACT), a service intended to provide intensive psychiatric and other support services to individuals with severe and persistent mental illness.<sup>12</sup> Professionals supporting Chien would have frequently observed conditions at Evergreen. Just before Evergreen was closed, Chien was hospitalized for attempting suicide with a knife.<sup>13</sup>

When Evergreen was officially shut down by Salt Lake County on January 26, 2022, state and county officials scrambled to find housing for the 17 residents. Individuals were sent to a variety of placements including homeless shelters, nursing homes, homes of family members and to Intermediate Care Facilities for Individuals with Intellectual Disabilities ("ICFIDs").<sup>14</sup> The state placed Chien and three other Evergreen residents in Hidden Hollow Care Center, a private intermediate care center/nursing facility for people with intellectual disabilities.<sup>15</sup> Chien's placement at Hidden Hollow was strange because Hidden Hollow is



licensed to serve only individuals with intellectual and developmental disabilities, whereas individuals living at Evergreen were all diagnosed with severe and persistent mental health conditions.<sup>16</sup>

Multiple state staff from the Utah Department of Health, Utah Department of Human Services, Utah Division for People with Disabilities, as well as staff at Hidden Hollow Care Center, indicated there were concerns Chien did not have a developmental disability in order to qualify for care at Hidden Hollow Care Center, but that he needed to stay because there were no other facilities available to him.<sup>17</sup> The three other individuals sent to Hidden Hollow from Evergreen were quickly discharged because they did not have a qualifying disability that would allow them to remain at the facility.<sup>18</sup> When Chien remained at Hidden Hollow, there was a delay switching his Medicaid from Salt Lake County to Utah County, which created a delay in refilling his prescriptions and receiving psychiatric care.<sup>19</sup> Through the course of our investigation we were unable to locate a care plan for Chien while residing at Hidden Hollow Care Center and there were delays filling Chien's psychotropic medications after his refills ran out.<sup>20</sup> Chien received a psychological evaluation and was curiously given a diagnosis of intellectual disability as the records available for review demonstrate that

Chien successfully attended high school and had no record of disability prior to age 18 as required by the Intermediate Care Facility admission rules.<sup>21</sup> After this diagnosis, Hidden Hollow officially admitted Chien on March 24, 2022 and began billing Medicaid for Chien's services as of that date.<sup>22</sup>

After moving to Hidden Hollow, Chien no longer had access to his previous mental health providers, faced apparent delays in accessing his medication, and began to experience more serious psychiatric symptoms.<sup>23</sup> According to Chien's brother Nick, when they visited together, Chien would say he wasn't being cared for. Additionally, records and interviews indicated that Chien went approximately 1-2 weeks without his psychotropic medications (including Clozaril, a psychotropic medication that can help alleviate suicidality in people with schizophrenia and schizoaffective disorder).<sup>24</sup> Chien attempted suicide on the afternoon of April 10, 2022, by running out and lying down in a busy road in front of Hidden Hollow Care Center.<sup>25</sup> The Hidden Hollow Care Center administrator pulled Chien out of the street but apparently did not notify facility management of this suicide attempt, did not inform the incoming night shift staff at Hidden Hollow Care Center, or take any increased precautions to monitor Chien at that time.<sup>26</sup> Chien's brother Nick visited that very evening and was also

not told that his brother had had a suicide attempt earlier that day, but Chien let him know that he had not been receiving his medications.

Very early the next morning, Chien died by suicide after running out in front of the vehicle of a Hidden Hollow staff member.<sup>27</sup> When Chien was hit by the vehicle, the staff member was leaving Hidden Hollow while on-shift to get food, leaving another staff member as the sole caretaker for approximately 32 individuals.<sup>28</sup> While leaving during a shift is against agency policy, staff confirmed this was a common practice.<sup>29</sup>

Licensing reports for Hidden Hollow reveal the facility was cited for persistent and ongoing abuse and neglect of residents including serious physical harm to residents, a lack of care planning, and a failure to implement care plans even prior to Chien's death.<sup>30</sup> Despite serious violations, fines for these deficiencies ranged only from \$200 to \$1,000.<sup>31</sup> Licensing issued an immediate jeopardy finding<sup>32</sup> on multiple occasions, but restrictions were quickly lifted by the state in each instance.<sup>33</sup> In one particularly egregious incident in March of 2021, an individual who required line of sight supervision was left alone in a room with his roommate.<sup>34</sup> The individual inflicted serious bodily harm on the roommate, resulting in the roommate

being blinded in both eyes.<sup>35</sup> The individual had already injured the roommate's eyes and face the week before, had broken the roommate's arm which required emergency surgery and a hospital stay, and had injured other residents.<sup>36</sup> Based on this incident, Licensing placed Hidden Hollow on immediate jeopardy with a conditional license in March 2021 and issued a fine of \$1,000; however, immediate jeopardy was removed in April 2021.<sup>37</sup> Chien's death occurred just a year later in April 2022 and resulted in a similarly lenient action by Licensing: Hidden Hollow was fined \$8,000 and not allowed to admit more residents for only one month after Chien's death.<sup>38</sup> Distressingly, the \$8000 fine was not solely attributable to Chien's death and covered an incident where Hidden Hollow staff physically assaulted a resident resulting in a broken tooth.<sup>39</sup> Hidden Hollow continues to admit and care for individuals with intellectual and developmental disabilities.



***It seemed that nothing happened when [Chien was] killed” and “I am still angry with people [who] don’t care my brother died.”***

Quoting Nick Nguyen “it seemed that nothing happened when [Chien was] killed” and “I am still angry with people [who] don’t care my brother died.” “I wished that he had lived with me” and he would have “never died.” “I am still crying now.”

## Licensing Lack of Oversight in Other Long Term Care Facilities

Chien Nguyen's death is just one example of the deficient oversight of Utah's long term care system. As the Protection and Advocacy agency for the state of Utah, the Disability Law Center has repeatedly seen Licensing and other state agencies ineffectively protect individuals with disabilities in long term care facilities. State regulators seem to operate in a culture of protecting businesses rather than protecting people from harm when they levy insubstantial fines and prioritize keeping troubled facilities open. This practice is not only dangerous for the individuals served in these facilities, but also threatens federal funding allocated to the state for oversight of these services.

### *Private Care Homes*

Unfortunately, the lack of oversight and poor conditions in long term care for people with

mental health disabilities are not unique to Evergreen. DLC staff have observed yet another unlicensed board and care home with similar reports of poor conditions including a lack of hot water and bed bug infestations so bad that individuals have needed to seek care in a hospital. Advocates, professionals, and state/local government workers cite a lack of access to appropriate residential services for individuals with severe and persistent mental health conditions as an ongoing issue and as a reason officials are reluctant to shut down facilities that provide inadequate care.<sup>40</sup>

### *Intermediate Care Facilities*

The DLC receives monthly reports from the state regarding deaths in Intermediate Care Facilities. When the DLC initially requested this information, Department counsel responded “Facilities Licensing does not collect names or information about individuals that passed away while residing in a long-term care facility. Medicaid also does not collect that type of information...so there is not a system that collects and maintains the cause of death.”<sup>41</sup> Concerningly, Counsel also informed us that neither DOH Licensing nor the state Medicaid office conduct fatality reviews of deaths that occur.

The DLC has seen a pattern of alarming deaths in these facilities, which is especially concerning given the lack of a fatality review process. Some examples of concerning deaths between 2018 and present day in these facilities include the following:

- ICF 1: 3 individuals have died from aspiration, 2 individuals died from septic shock and 1 person died of malnutrition.
- ICF 2: 1 individual died from choking, 1 individual died from malnutrition, 1 individual died from sepsis and 2 individuals died from aspiration.
- ICF 3: 1 person died from blunt force trauma and another from aspiration.
- ICF 4: 1 person died from a traumatic head injury and 1 person died from sepsis.

### *Nursing Homes and Assisted Living Facilities*

In 2021, the DLC published a report entitled *The Dangers of Institutional Living: COVID-19 in Utah's Long-term Care Facilities*<sup>42</sup> which documented that a lack of oversight in long term care settings contributed to an incredible loss of life and worsening facility conditions during the pandemic. For example, Sandy Health and Rehab, had the highest number of deaths from COVID-19,<sup>43</sup> a troubling pattern of understaffing and failed to

meet quality care standards. Since the release of our report, two additional Licensing surveys have shown continued issues with care.<sup>44</sup>

In February of 2022, the facility was fined for cleanliness issues. In March of 2022, Licensing noted multiple deficiencies, but no fines were assessed. Licensing found that transmission-based precautions to prevent the spread of disease were not being followed by employees. Additionally, multiple residents and their family members reported finding residents in the same clothes for two or three days, family members needing to comb hair, brush teeth, dress and cut fingernails of residents, residents choosing to spend most of the day in hospital gowns so the facility did not have to worry about helping with dressing, and family members needing to spend hours each day with residents to help care for them. Current quality rating data from CMS evidences similar concerns about resident care—70% of residents in the facility have pressure ulcers that are new or worsened compared to the national average of 2.8%.<sup>45</sup>

### *Youth Residential Treatment Facilities*

There has also been a disturbing lack of appropriate oversight of Youth Residential Treatment Facilities (“YRTFs”). Utah leads the nation in the number of children who are sent to YRTFs, settings that

promise treatment for youth with behavior, mental health, and other problems. In 2021, after numerous serious incidents, Utah passed legislation championed by State Senator Mike McKell with enhanced oversight of YRTFs. Changes included limits on restraint and seclusion, more licensing visits and new reporting requirements for YRTFs. After the changes the licensing director described past efforts as providing “technical assistance” with the goal of working with youth residential treatment businesses, rather than punishing them<sup>46</sup> but more recently “have realized that we need to hold these programs accountable.”<sup>47</sup>

Despite these reforms, Utah Licensing has continued to repeatedly fail to protect children in these facilities from serious harm. In January 2022, a girl at Maple Lake Academy died from alleged medical neglect; licensing continued to allow the facility to operate, but not admit new residents. Four months later Maple Lake Academy “failed to seek immediate medical attention for a client that was involved in an accident in which they hit their head on the pavement, lost consciousness and had multiple vomiting episodes.” While Licensing took steps to revoke Maple Lake’s license, the facility was permitted to stay open.<sup>48</sup> Maple Lake Academy administrators said in a statement that they were “gratified” that they reached a resolution with





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the state. The director of the Office of Licensing at the time stated that if the "Office of Licensing determines that the provider is walking in the right direction, our job is not to close them but to support their efforts to become better providers."<sup>49</sup>

In December 2022, a child at Diamond Ranch Academy died from sepsis due to alleged medical neglect after she had asked for treatment for weeks for her vomiting and severe pain. She was the third child to die at the facility since it opened in 1999.<sup>50</sup> Even after the death, "at Diamond Ranch Academy alone, the police were called 38 times between January 2022 and February 2023, according to police records obtained by Youth Today under state open records laws. About a third of the calls were for altercations between students, which centers are required to report under the new regulations. The others were for investigations of what police

records describe as alleged rapes, assaults and injuries including an adult who was issued a citation for assault against a juvenile who sustained minor injuries, a student who was transported to the hospital for treatment of injuries sustained after falling more than 20 feet due to what police records describe as a suspected suicide attempt, and three boys who police deemed missing after running away from campus. None of those incidents resulted in state sanctions."<sup>51</sup> In response to this most recent death, Senator McKell states "this is an industry that needs to be updated," said McKell, "I'm not comfortable with where we're at right now."<sup>52</sup> As of today, Diamond Ranch is still operating under a conditional license.<sup>53</sup>

## Conclusion

Across service systems, Utah licensing and state agencies have failed to protect people with disabilities. Time and time again, facilities that mistreat vulnerable residents and fail to provide them with appropriate treatment or even humane living conditions continue to operate. With the threats long term care residents face from abuse, neglect and lack of treatment and the potential loss of federal funding, it is imperative that the state of Utah act now to ensure appropriate oversight of long-term care facilities. The DLC recommends

that state agencies and policy makers work with consumers and other advocates to enhance regulations, assure quality oversight, and to build a system that ensures safe and effective care for people with disabilities in the state of Utah.

<sup>1</sup> Prior to August 2022, the Department of Health and Department of Human Services were two separate agencies that had separate licensing offices that oversaw different facilities; however, they are now all housed in one office.

<sup>2</sup> <https://www.cms.gov/files/document/qso-22-12-all.pdf>

<sup>3</sup> <https://www.ksl.com/article/50351051/midvale-care-center-residents-lived-amid-raw-sewage-without-heat-police-say>

<sup>4</sup> Records on file with the DLC, including document production from Salt Lake County.

<sup>5</sup> Records on file with the DLC, including document production from Salt Lake County and DHHS.

<sup>6</sup> Records on file with the DLC, including document production from DHHS.

<sup>7</sup> <https://dsamh.utah.gov/wp-content/uploads/2020/10/Salt-Lake-Co-FY21-Area-Plan.pdf>

<sup>8</sup> Records on file with the DLC, including document production from DHHS.

<sup>9</sup> Records on file with the DLC, including document production from VBH.

<sup>10</sup> Id.

<sup>11</sup> Records on file with the DLC, including document production from DHHS and DDMS.

<sup>12</sup> Records on file with the DLC, including document production from VBH and DHHS.

<sup>13</sup> Records on file with the DLC, including document production from VBH.

<sup>14</sup> Records on file with the DLC, including document production from DHHS.

<sup>15</sup> Records on file with the DLC, including document production from DHHS, Salt Lake County, DDMS and interviews with DDMS staff.

<sup>16</sup> Hidden Hollow Care Center is owned by Developmental Disability Management Services LLC (“DDMS”), and provides care for individuals with developmental disabilities as a contracted provider under the Medicaid state plan. DDMS operates 5 ICFs in the state of Utah and has a nationwide footprint.

<sup>17</sup> Records on file with the DLC, including document production from DHHS, DDMS and interviews with DDMS staff.

<sup>18</sup> Id.

<sup>19</sup> Records on file with the DLC, including document production from DDMS and interviews with DDMS staff.

<sup>20</sup> DDMS notes show that Chien was taken for labs on 4/7/2022 and a prescription was sent to the pharmacy that same day. The medication was sent to Hidden Hollow on 4/10/2022, but a nurse was not there to check it in, so Chien was not administered the medication prior to his death by suicide.

<sup>21</sup> Records on file with the DLC, including document production from DDMS.

<sup>22</sup> Records on file with the DLC, including document production from DHHS, DDMS and interviews with DDMS staff.

<sup>23</sup> Records on file with the DLC, including document production from DDMS and interviews with DDMS staff.

<sup>24</sup> Id.

<sup>25</sup> Id.

<sup>26</sup> Id.

<sup>27</sup> Id.

<sup>28</sup> Id.

<sup>29</sup> Records on file with the DLC, including interviews with DDMS staff.

<sup>30</sup> Records on file with the DLC, including publicly available licensing documents.

<sup>31</sup> Id.

<sup>32</sup> An immediate jeopardy finding means a facility has demonstrated noncompliance with federal regulations resulting in a serious adverse outcome or likely serious outcome and requires an immediate corrective action to prevent serious harm or death from occurring or recurring.

<sup>33</sup> Records on file with the DLC, including publicly available licensing documents.

<sup>34</sup> Id.

<sup>35</sup> Id.

<sup>36</sup> Id.

<sup>37</sup> Id.

<sup>38</sup> Id.

<sup>39</sup> Id.

<sup>40</sup> Records on file with the DLC, including document production from DHHS; additionally, the DLC has been told this information during monitoring visits and interviews with professionals serving the mental health disabilities population.

<sup>41</sup> Email in possession of Disability Law Center.

<sup>42</sup> <https://disabilitylawcenter.org/resources/the-dangers-of-institutional-living-covid-19-in-utahs-long-term-care-facilities/>

<sup>43</sup> These numbers were pulled from federal data collected by CMS from long-term care facilities during the Covid-19 pandemic. DHHS officials dispute the number of deaths reported by CMS at Sandy Health and Rehab as reporting errors. Information publicly available from CMS; data pulled from STARPRO Analyzer program on file with DLC.

<sup>44</sup> Information publicly available from CMS; data pulled from STARPRO Analyzer program on file with DLC.

<sup>45</sup> Id.

<sup>46</sup> <https://www.apmreports.org/story/2022/04/12/utah-increased-oversight-of-troubled-teen-industry>

<sup>47</sup> Id.

<sup>48</sup> [https://drive.google.com/file/d/19Vni-8w7hAJ5rZX\\_y1bQZ6d1DIHkPzJX/view](https://drive.google.com/file/d/19Vni-8w7hAJ5rZX_y1bQZ6d1DIHkPzJX/view)

<sup>49</sup> [https://www.sltrib.com/news/2022/08/18/utah-regulators-back-down-now/?npos=2&utm\\_source=Salt+Lake+Tribune&utm\\_campaign=d31e8a3f64-EMAIL\\_CAMPAIGN\\_2022\\_08\\_18\\_03\\_58&utm\\_medium=email&utm\\_term=0\\_dc2415ff28-d31e8a3f64-45840201](https://www.sltrib.com/news/2022/08/18/utah-regulators-back-down-now/?npos=2&utm_source=Salt+Lake+Tribune&utm_campaign=d31e8a3f64-EMAIL_CAMPAIGN_2022_08_18_03_58&utm_medium=email&utm_term=0_dc2415ff28-d31e8a3f64-45840201)

<sup>50</sup> <https://www.fox13now.com/news/local-news/family-speaks-out-amid-lawsuit-against-utah-boarding-school-after-teens-death>

<sup>51</sup> <https://youthtoday.org/2023/04/the-death-of-17-year-old-taylor-goodridge-is-the-latest-test-for-utahs-will-to-regulate-the-troubled-teen-industry/>

<sup>52</sup> <https://www.fox13now.com/news/local-news/family-speaks-out-amid-lawsuit-against-utah-boarding-school-after-teens-death>

<sup>53</sup> <https://drive.google.com/file/d/1-vFIU3iBQ2UaVtXTTSqnOoDDP7hqWuuA/view>

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