DISABILITY LAW CENTER

Profits Over People

Utah's Oversight Failures Create a Lifetime of Harm.

September 2026

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 and has federal statutory authority to conduct this work. The materials referenced in this report have been pulled from client interviews, staff observations, investigation findings, police records, records from the Utah Department of Health and Human Services ("DHHS"), and news reports.

Nationally, there has been growing concern from advocates, policymakers, and consumers regarding the quality of long-term care as some industry providers have focused on profit maximization. Pressure to demonstrate high returns can lead to facilities looking for ways to reduce expenditures. This leads to cost-cutting measures such as understaffing, reducing staff wages, reducing equipment and supplies, and replacing highly skilled and credentialed staff with low skilled labor. These measures create a real risk of resident harm in an industry that is largely funded by taxpayer monies. To prevent harm and ensure taxpayer monies are appropriately spent on their intended purpose, state governments must ensure they can provide effective oversight.

This report details the Disability Law Center's examination of Utah's long-term care system to identify systemic causes of harm. Through investigations of facilities that provide different types of care across a lifetime, we have identified vulnerabilities in our service system that put people with disabilities at risk and deprive individuals of care. We have seen many good long-term care providers that place patient care at the center of their business. However, we have also investigated facilities that have generated enormous profits funded by taxpayers while egregiously harming people with disabilities in their care. We urge the state and legislature to take meaningful action to close these loopholes and ensure the safety of all long-term care residents.

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Upper Payment Limit Nursing Facilities

The Upper Payment Limit ("UPL") program was created to help states draw down higher reimbursement rates in rural healthcare facilities. Utah implemented its version over a decade ago. Since then, three city and county hospitals (Beaver Valley, Gunnison Valley, and Kane County) have acquired ownership of a majority of nursing homes that operate across the state. The ownership appears to be largely in name only—while delivering large profits for the privately run and operated nursing facilities that stretch beyond rural communities. These funds were explicitly intended to support higher staffing levels and improved care quality. But Utah's experience suggests otherwise. A report by the Utah State Auditor found 51% of the approximately $1.2 billion nursing facilities collected in the last decade were used on administrative expenses, including owner compensation, administrative costs, and hospital operating expenses. The audit also found that funds meant for skilled nursing facilities were instead used for improvements at the rural hospitals, including the $30 million Beaver Valley Wellness Center with a fitness floor, pickle ball courts and a lazy river.

Paramount Health and Rehabilitation ("Paramount") is a UPL nursing facility in Millcreek, owned by Beaver Valley and operated by the Ensign Group. In visits to Paramount, the DLC has observed unsanitary conditions with residents wearing soiled clothing. On one visit multiple residents were dressed only in briefs without any other covering. The facility, including resident living areas and bathrooms, appeared unclean; resident mattresses were on the floor in some rooms, and DLC staff observed strong, unpleasant odors throughout the building. Inspections by state licensors have made similar observations documenting dirt in common areas and the presence of body, bowel movement, urine, and vomit odors. Patient rooms are shared and feel cramped, and it does not appear the rooms have gone through any current updates.

In December of 2025, a resident caught on fire after being left unsupervised while smoking and died soon after from the significant burns. The resident was taken out to smoke by a staff member who regularly worked at one of Paramount's sister facilities. According to the resident's care plan, he was supposed to be supervised at all times while smoking due to a medically determined risk of injury. The resident was taken outside, and the staff member went into the building to work with another patient. The resident's shirt caught on fire, and there were no staff members present to help. Several other residents attempted to help extinguish the fire by hand and with various liquids, including hot coffee. One resident suffered burns while trying to help. Residents called for help, and Paramount staff members extinguished the fire by wrapping the resident in a fire blanket. The resident was alert and oriented after and said he was in pain. He would later be admitted to the hospital and died after suffering third degree burns over a significant portion of his body. The individual who lost his life had lived at Paramount for several years, had friends who cared about him, and was a Vietnam Veteran.

This incident was investigated by the Division of Licensing and Background Checks ("DLBC") which concluded that Paramount failed to provide adequate supervision to prevent accidents. The staff members involved in the resident's death admitted that; 1) the staff member working with the resident did not know the resident's care plan required he be supervised while smoking to avoid injury, and 2) the director of nursing did not know the temporary staff member had taken the resident outside and left them alone. Missing from DLBC's records was any inquiry about why the facility was utilizing staff from another facility

which should have indicated a possible lack of staff. The records show DLBC staff found Paramount had corrected the deficiency a month later stating that the licensor "verified that the provider ensured residents were assessed and provided supervision and assistive devices, when needed, to safely smoke cigarettes as stated by the rule." The records do not mention any requirements for the facility to ensure temporary staff are trained on patient care plans and adequately supervised when providing care.

Alarmingly, this was not the first time a patient had been burned at Paramount and a similar incident occurred just a year before in 2024. According to DLBC's website Paramount was fined $10,000 for its failure in the 2025 incident to supervise the resident who died and $1,500 for the resident whose hand was injured. In contrast, news reports show the facility has received an additional $22.8 million in UPL payments between 2017 and 2026.

The $22.8 million in UPL fundings for Paramount was meant to improve patient care, but how that money has been invested is not readily apparent. The building has had some very recent cosmetic upgrades in the hallways, but overall, the facility is outdated and has many areas that are visibly unclean with concerning odors. DLBC records paint a troubling history that patient care still requires significant improvements. In Paramount's 2024 survey, licensors cited the following:

- A resident's finger was partially amputated after becoming caught in a wheelchair, and another resident's finger was caught in a doorframe resulting in a fracture and deep laceration.
- A resident suffered repeated falls, resulting in a hip fracture; another resident suffered multiple falls resulting in multiple lacerations.
- 2 residents fell during transportation because they were not properly secured.
- A resident suffered a burn while smoking without adequate supervision; after a smoking plan was implemented, staff were unaware of the smoking plan and failed to implement it.
- A CNA allegedly terrorized a resident by mimicking hanging herself, then pinning a sheet over the resident's head and then pinning a rolled-up towel over the resident's neck.

DLC investigations have found other troubling UPL facilities, such as Sandy Health and Rehabilitation. Sandy Health and Rehab was fined after a resident with a known elopement risk left the facility. Staff refused assistance after being contacted by the police who had found the resident; staff told officers the resident could leave the facility whenever they wanted to. After this encounter the resident was transported to a hospital with second and third degree burns from the hot pavement after they fell out of their wheelchair

and was unable to move off the ground. It wasn't until the next day that staff realized the resident had not returned. Sandy Health and Rehab also spent many months as a special focus facility candidate – a designation that means the nursing home has demonstrated serious problems (including harm or injury) that have persisted over a long period of time. Despite obvious questions over how the facility has made the required investments in patient care, the facility has received $33.8 million in UPL payments over the last 11 years.

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Youth Residential Treatment Facilities

Provo Canyon School

Utah is home to numerous residential treatment facilities that hold themselves out as providing intensive, individualized, therapeutic care for youth with complex mental health and behavioral needs. Many children are sent to Utah from out of state, and public records requests have shown sizeable public monies being spent on care. The DLC's monitoring and investigation at Provo Canyon School ("PCS") raises significant questions about where money was spent.

Local reporting from Montana news outlets showed the state's Department of Public Health and Human Services paid $4 million to PCS in 2026, and $26 million in total over the last decade. Children from Montana were only one subsection of its population. The DLC met children from California, New Mexico, Idaho, and Wyoming—all sending payments from state Medicaid programs, school districts, and in some cases private insurance with significant costs to families.

While Utah regulations require facilities like PCS to maintain minimum staffing ratios for direct care staff, youth treatment facilities are required to provide additional staffing when necessary to meet the needs of children. During our visits PCS staff maintained that they strictly adhered to minimum ratios, despite evidence that students required higher ratios to prevent fights, implement care plans, and ensure children could be safely overseen. During conversations with staff, it appeared PCS was unable to provide a 1:1 staffing ratio, even for students who were at risk of harm due to their severe psychological needs.

In conversations with children, PCS residents reported the facility had difficulty even maintaining minimum staff ratios and would pull from administrative, clinical, or office personnel to fill shortages. In one instance, the DLC learned that a staff member who worked in IT support was pulled in due to a staffing shortage. During his shift, children became frustrated and escalated, culminating in a riot which required police intervention. Residents reported that staff were not trained to manage the situation and did not appear to understand de-escalation techniques. Ultimately, staff relied on police intervention after staff and residents were injured during the incident.

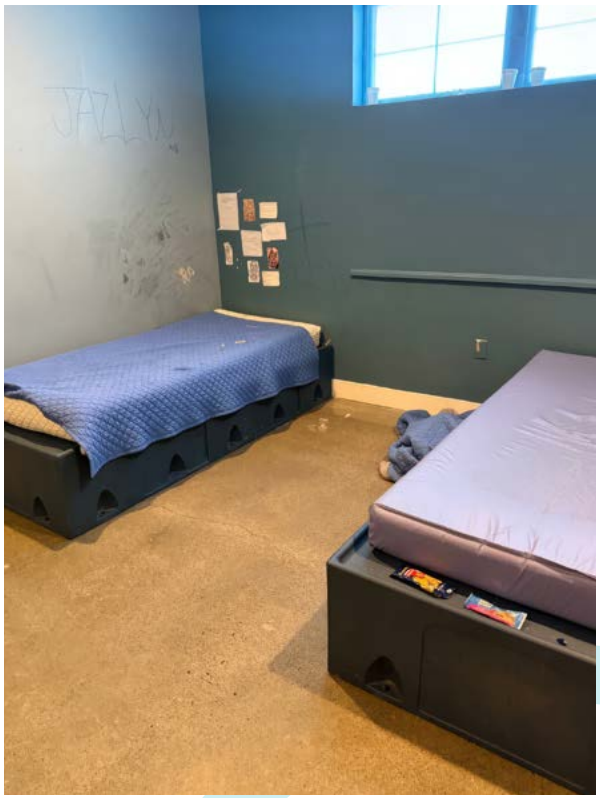
> "***Eight Program Managers*** *did not meet the qualifications required for their positions,* ***and the facility was fined only $150.***"

Children also reported a high percentage of staff turnover, untrained staff, and staff who did not appear fit for their position. On June 23, 2026, the DLBC conducted a credential review as part of an investigation at PCS's Springville Campus. The review found that 8 Program Managers did not meet the qualifications required for their positions and the facility was fined only $150.

Understaffing and untrained staff also create conditions that can lead to abuse and neglect. During 8 monitoring visits to PCS campuses over the summer, DLC staff conducted 50 interviews with residents. Information shared by children during these interviews, coupled with our observations, resulted in deeply troubling findings. One resident reported an attempted suicide in which they lost consciousness. However, the resident was not taken to the hospital for medical evaluation nor were they provided 1:1 staffing despite suffering from continued suicidal ideation. Another child was attacked by multiple students and beaten over the course of two days, resulting in hospitalization.

Multiple residents at the Springville campus reported a staff member was grooming girls, handing out pictures of himself with his shirt off and encouraging girls to sit on his lap. DLC staff observed multiple students with large, gaping wounds due to self-harm which were openly exposed and without bandages. Many children reported regular fights between residents in which staff would fail to intervene or de-escalate before students were physically harmed. Multiple residents reported being denied access to the restroom; one child said they were forced to urinate in a cup in front of other residents and staff.

Children at the Provo campus reported that staff members antagonized, swore at and demeaned the residents; in one instance residents were forced to get on their hands and knees and bark like dogs. Residents reported that some staff actively encouraged fights. We were also notified of multiple incidents involving rape and sexual assault, routine elopements from the facility, and a pervasive sense among residents that they felt unsafe.



A facility that is well staffed with trained professionals should have the ability to create and implement effective care plans. While children may experience harm or exhibit ongoing and difficult behaviors in well-staffed facilities, the level of harm that occurred at PCS raises serious questions about how the facility used program income and why there were such obvious staffing deficiencies that were not corrected by increasing pay and creating incentives to attract qualified staff.

Additional concerns raised by residents centered on the quality and consistency of mental health care they were receiving. Our observations found PCS generally provided one private therapy session and one family therapy session a week regardless of the client's diagnosis or need. While some children reported more sessions, a large majority reported they were limited to one private session even if they needed more therapeutic support. Residents also expressed concerns with canceled sessions and an overall frustration with the lack of coping and life skills being taught and implemented. Several students also reported being told PCS would not provide specific treatment for children with substance use disorders.

Typically, facilities caring for individuals with complex disabilities will have individualized treatment plans and base therapeutic sessions on clinically documented needs. These treatments are then included as part of a care plan that is implemented throughout the day by direct care staff. This type of individualized care can be more costly because it requires staffing based on client need, well-qualified professionals, and ongoing evaluation to adjust as a client's needs change. These costs can cut into profit margins, and we have seen facilities reduce expenditures by using a one-size fits all model regardless of client need. Based on our observations, the DLC has ongoing concerns that PCS was not making the type of expenditures of public dollars they were receiving that was necessary to provide individualized care for children in need of help.

DLC staff documented similar treatment concerns at another youth facility, New Beginnings Behavioral Health. There, residents reported their private therapy sessions often consisted of either virtual therapy sessions or watching a therapist on YouTube, sometimes at double speed to shorten the amount of time spent in "treatment." The same residents shared group therapy sessions often consisted of playing video games or watching movies. Records provided by the State showed over $800,000 in federal and state funds were paid to New Beginnings Behavioral Health between 2024 and 2026.

State Action

The DLC acknowledges and applauds the swift action by Utah regulators to revoke the licenses of PCS after substantiating the harm to residents in PCS's care. Their prompt investigation and diligent work prevented further abuse and protected vulnerable children. We also believe the passage of S.B. 127 in 2021 was a meaningful step to addressing longstanding problems within the youth residential treatment industry. However, the State lacks the resources to ensure the full protection promised by this legislation. As recommended below, we believe the state must take steps to improve oversight to ensure that children are safe and public monies are being used to provide adequate treatment.

Safe and Sound Services

On February 6, 2026, three men with developmental disabilities in the care of Safe and Sound Services, Colton Moser, Mosa'ati Moa and Tim Jones, died from carbon monoxide poisoning after being left without supervision in a running car in a closed garage for approximately four and a half hours while their direct support worker was inside. All three men died that day. This tragedy occurred because DHHS allows high risk providers to serve individuals with complex support needs and large budgets to support those needs without appropriate oversight and accountability. This was not the first time the worker in question had neglected people receiving services, nor was it the first time Safe and Sound Services and related providers had placed vulnerable adults with disabilities at risk of harm. The DLC has seen a pattern of smaller, newer providers serving individuals with high support needs who have large budgets through DHHS, and then failing to provide appropriate training, staffing levels and oversight. We are concerned that a small number of providers may be exploiting gaps in oversight to divert substantial DHHS-funded care budgets toward profit while failing to provide the critical services needed by individuals with complex needs.

At the time of the three deaths, DHHS should have known that Safe and Sound was a dangerous provider that was failing to appropriately meet client support needs. Before the deaths, DHHS had been notified of incidents of harm involving Safe and Sound including many altercations during transport, medication errors, physical assaults, and failure to provide medical care after injuries. None of these incidents resulted in significant repercussions for the provider. Not until after the incident involving the three men did DHHS cite Safe and Sound for not providing supervision commensurate with the behaviors and needs of clients, not ensuring staffing ratios, and not protecting clients from abuse and mistreatment.

DHHS inspections of Safe and Sound in the years leading up to the tragedy identified instances in which direct care staff worked unsupervised with people with disabilities without completing required background checks, as well as failures to maintain adequate training records and ensure employees completed required training. It appears from the records that since March 2024, DHHS either conducted these reviews remotely or inspected the program when no clients were present. Under those circumstances, inspectors had little opportunity to talk with clients and observe how services were actually being provided or identify problems that would only become apparent while staff were supporting clients.

Had DHHS engaged in more frequent in-person visits that included observations of staff interactions and interviews with people in services, it likely would have identified significant problems with Safe and Sound much earlier. Just one month before the three men were killed, the same staff member received a written warning from Safe and Sound for “client abandonment” after leaving three clients unattended for 30 minutes. The employee also told investigators that he had previously brought clients to his home and left them in the van. It is unclear whether Safe and Sound reported these incidents to DHHS. However, more frequent and thorough in-person inspections would have provided DHHS greater opportunity to identify unsafe supervision practices before the tragedy occurred.

> *At the time of the three deaths, DHHS should have known that **Safe and Sound was a dangerous provider** that was failing to appropriately meet client support needs.*

After the deaths, DHHS took emergency action against the day program site, and then the DHHS Office of Service Review ("OSR") visited six residential sites to assess the safety of individuals who remained in Safe and Sound's residential services. Only one of the six settings appeared to have no significant problems. The others raised serious concerns about resident safety and appropriate staffing levels:

- At one setting, family members reported poor communication and an elopement and said they had planned to remove their loved one from services even before the deaths.
- At another, there was no heat or running water, the home smelled foul, and there were signs of possible hoarding. Staff did not understand how to follow Adult Protective Services ("APS") or incident reporting requirements, and OSR staff felt unsafe entering the residence.
- At a third, staff reported that a resident had returned from the day program with a broken tooth and black eyes and later had scratches on his neck. Staff also reported ratios as high as one staff member to 15 individuals at the day program and a separate incident in which a client allegedly choked another participant.
- At a fourth, one resident reported being yelled at, denied access to their money, and sleeping on the floor because they only had an air mattress. Another resident was living in a filthy basement room with no door and only a mattress on the floor. They appeared unbathed and wore dirty clothing. The door to the upstairs was missing and staff admitted to locking them in the basement at night.

> *Only **one of the six** settings appeared to have **no significant problems."***

These complaints all demonstrate the provider was not using the money appropriated by DHHS to provide even basic utilities or a clean environment. Staffing ratios were dangerously low and insufficient to provide the care the state had contracted for. Additionally, staff were obviously not qualified to care for individuals with complex needs as shown by locking individuals in a basement, failing to provide adequate medical attention when necessary, and failing to follow a 1:1 staffing ratio. Finding and attracting qualified staff often takes an investment of resources by a provider that Safe and Sound arguably failed to make.

Furthermore, Safe and Sound likely shouldn't have been issued licenses and certifications in the first place given the structure of its residential program and its relationship to other problematic providers. Residential providers must get a license, which requires more oversight, instead of a certification, if there are more than three residents living at the

same address. Safe and Sound's documentation clearly indicated that six individuals resided at its residential sites, with three on the main floor and three in the basement. Despite this, DHHS allowed the homes to operate under a certification rather than requiring a residential license, which would have subjected the provider to more requirements and oversight. DLBC didn't cite this problem until after the deaths, but the addresses showing 2 certified sites at the same home were readily available before then.

DHHS has a small but notable percentage of developmental disability providers who have closed down after a serious incident occurs only to reopen under the name of a relative or other closely connected individual. Utah rules prohibit individuals whose human services license, Division of Services for People with Disabilities ("DSPD") certification, or contract has been revoked from being associated with another provider for five years. Utah Admin. Code R501-1-12(15)–(16); R501-23-4(6)(b). DHHS does not adequately identify these relationships or effectively prevent problematic providers from opening under another name. The owners of Safe and Sound appear to be related by family to multiple other providers, including providers that the DLC has filed complaints on and reported to DHHS for causing serious harm to people in

services. Additionally, public records seem to show that four of the siblings of the owner of Safe and Sound operate additional DHHS provider agencies, but to date it doesn't appear that DHHS has investigated these connected providers.

Given this history, DHHS should have been aware of the serious and foreseeable risks posed by the provider. States are required to provide assurances that necessary safeguards are in place to ensure the health and welfare of Medicaid waiver beneficiaries. The mix of large client budgets and a startling lack of oversight have allowed a limited number of providers to place people in homes and day programs in unsafe conditions with a dangerously low number of staff. If the state cannot ensure safety, it risks losing Medicaid dollars by failing to comply with federal law to ensure the safety of waiver participants.

Conclusion and Recommendations

Our investigations have identified common areas that, if improved, would greatly enhance the safety of long-term care and ensure taxpayer funds are being used as intended. During our investigations we found common concerns of a large amount of public funding with a lack of transparency on how it is spent, a failure to prioritize resident care over the potential for profits, and a weak oversight system that does not have the resources necessary to protect patients. While we understand providers must remain profitable to continue operating, some of the patient harms we've seen and detailed above have resulted from egregious conditions, a lack of competent staff, and even an inability to meet basic needs in some instances. Programs like the Upper Payment Limit program have brought in a massive $1.2 billion, and facilities are unable to explain how over half of that money was spent on its intended purpose. Additionally, the State should not allow facilities to base staffing decisions on anything other than client need because failing to do so will always result in resident harm.

We also strongly recommend the State invest in more staffing for APS, OSR, and particularly for DLBC. In many of our investigations, we see providers engage in the same type of harm for years without increased fines or repercussions. The failure to identify systemic causes of harm and make corrections only exposes residents to repeat and escalating incidents that can sometimes lead to a loss of life. This failure also allows important public monies that have been allocated for patient care to be diverted away from its intended purpose. Below are specific recommendations we believe would strengthen resident protections and protect the use of public funds.

1. Require Transparency and Prioritize Resident Care

a) Ensure full transparency in the use of federal funds, including UPL payments, and require that these resources prioritize direct care.

b) UPL providers should be required to publish annual reports detailing how much money was received through the program, how much was used for administration, and how much was used for improving care including what specific measures were taken to improve care.

c) Publish complete survey reports for state regulated facilities for the last 5 years and publish surveys for federally regulated facilities which currently require a public records request.

d) Expand reporting for DSPD-certified settings and host homes.

e) Adopt state-level staffing requirements for nursing homes (Utah can act despite opposing the federal rule).

f) Rebalance funding toward home and community-based care, which is safer and more cost-effective.

> *We see providers engage in the* ***same type of harm for years without increased fines or repercussions."***

2. Improve Requirements for Providers

a) Require providers to demonstrate capacity to safely and effectively care for individuals before receiving a license.

b) Consider credentialing requirements for administrators and other positions at long-term care facilities.

c) Ensure that uniform health and safety training is required for providers and provide technical assistance resources for providers to prevent harm from occurring.

d) Require a portion of UPL payments to be dedicated to raising staff salaries, hiring staff, and training staff.

> *"The failure to identify systemic causes of harm and make corrections* ***only exposes residents to repeat and escalating incidents that can sometimes lead to a loss of life."***

3. Provide Adequate Resources for Oversight

a) Align initial and ongoing licensing fees with provider revenues and oversight costs.

b) Currently civil penalties issued by DLBC are designated for the General Fund. These monies should instead be redesignated to make improvements in the DLBC.

c) Reinvest DHHS' excess UPL licensing and administrative fees into inspections and enforcement.

d) Increase staffing levels, compensation, and funding for ongoing training for DLBC, OSR, and Division of Child and Family Services/APS to ensure these agencies have the capacity to effectively fulfill their oversight and investigative responsibilities.

e) Ensure regulators have the technology, databases, and other tools necessary to effectively monitor and enforce compliance, including systems that allow agencies to share, track, and coordinate information about providers across departments.

Questions?

We're always here to help!

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