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IN THE THIRD JUDICIAL DISTRICT COURT

FOR THE COUNTY OF SALT LAKE, STATE OF UTAH

M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F., M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E., M.O., Plaintiffs, vs. VISTA AT DIMPLE DELL CANYON, INC., VISTA SAGE, VISTA MAGNA, TONI MAZZAGLIA, KRISTIN ADAMS, RYAN PEPPER, and JOHN AND JANE DOES 1-50. Defendants.	**FIRST AMENDED COMPLAINT** (Jury Demanded) Civil No. 210901434 Judge Robert Faust Tier 3

SUMMARY OF CASE

Thousands of children are living at a Utah Residential Treatment Center at any given moment. These children arrive in Utah at their most vulnerable, suffering from a myriad of mental, emotional, and physical struggles. Many of them have been brought to Utah unwillingly. In some instances, they have been taken in the still of the night from homes across the country. Parents and

caregivers, desperate for help, acquiesce to these tactics in hopes they can find some remedy to whatever may be ailing their children.

Preying on this desperation is big business. It was estimated in 2015 that the industry in Utah accounted for just short of $500 million in gross domestic product.[1] Despite these profits, the half-a-billion-dollar industry has been riddled with criticism and was recently the subject of increased legislative scrutiny. In particular, the Utah legislature observed that oversight of the industry was lacking, and that practices of forced restraint, sedation, and isolation in particular had presented significant harm to children at these facilities. In passing the new legislation, the Utah State Legislators expressed embarrassment over the treatment of residents at these centers and acknowledged its own failures. The recent legislative changes were a welcomed step forward. But accountability must be laid at the feet of those who have profited through the victimization of the vulnerable.

Vista at Dimple Dell, Inc., Vista Sage, and Vista Magna, (hereinafter "Vista") are Utah-based companies that have three residential facilities located in Utah: Vista at Dimple Dell Canyon in Sandy, Utah, Vista Sage in Sandy, Utah, and Vista Magna in Magna, Utah. Vista holds itself out to be a residential therapeutic center for minors that is able to treat depression, dysthymia, trauma, eating disorders, attachment issues, substance abuse, non-verbal learning disorders, self-harm issues, psychological, emotional, or sexual abuse, Bipolar Disorder, Oppositional Defiant Disorder, anxiety or panic disorders, and Borderline Personality traits.[2] Vista employs licensed therapists and licensed clinical social workers to administer medical care and treatment. At the

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[1] Tennert, Juliette, Director of Economic & Public Policy at the Kem C. Gardner Policy Institute, University of Utah, "Economic Impact of Utah's Family Choice Behavioral Healthcare Interventions Industry," May 2016.

[2] *See* Vista website: https://dimpledellcanyon.com/clinical-services

relevant times, Vista had a schooling component called Stansbury Academy, which accepts FAFSA federal grant assistance, obtains federal grants promoting education, and assistance through the GI bill. Further, Vista received educational funding through federally funded school districts. Therefore, Vista is subject to regulation under Title IX.

Notwithstanding promises otherwise, Vista consistently engaged in abusive and harmful practices. In particular, Vista has employed treatment modalities that emphasized humiliation and ostracization by peers as well as forced physical and emotional isolation. Every decision and action taken by a resident was recorded and judged. Noncompliant residents were punished with isolation and loss of basic human privileges. Fear of being reprimanded, isolated, or punished governed almost every decision residents made, completely preventing any kind of real or substantive therapeutic benefit from the program. But perhaps worst of all, Vista pitted residents against one another. Residents were encouraged and coerced to belittle and berate one another, to report when others broke the rules, and to exploit emotional vulnerabilities.

Notwithstanding the aggressive management of residents' every movement, Vista took an incredibly relaxed position toward its staff hiring unqualified and predatory individuals. In one known instance, Vista's failures culminated in the sexual assault and abuse of a minor by one of its staff members. When Vista learned of the sexual abuse, staff members and therapists blamed the victim and further ostracized, humiliated, and isolated her from her peers. Accordingly, Plaintiffs, by and through counsel, complain of Defendants Vista Dimple Dell, Vista Sage, Vista Magna, Toni Mazzaglia, Kristin Adams, Ryan Pepper, and John and Jane Does 1-50 (collectively, "Defendants"), and allege as follows:

PARTIES, JURISDICTION, AND VENUE

1. The full names and identities of Plaintiffs are not disclosed in this Complaint to protect Plaintiffs' privacy as victims of trauma and assault. Plaintiffs' full identities will be made known to all parties subject to a confidentiality agreement.

2. Plaintiffs are now adults who were residents and students at various Vista Treatment Center locations in Utah from the years 2003—2019.

3. Vista at Dimple Dell Canyon is a Utah corporation.

4. Vista Sage is a Utah DBA.

5. Vista Magna is a Utah DBA.

6. Upon information and belief, Toni Mazzaglia, Kristin Adams, and Ryan Pepper are licensed treatment providers employed by one or more Vista facilities and treated one or more Plaintiffs during the relevant time period.

7. Plaintiffs claiming a medical malpractice action (M.M., B.N., and M.O., complied with the requirements of Utah Code Ann. § 78B-3-401, *et seq*., governing pre-litigation notice and hearing.

a. Plaintiffs M.M., B.N., and M.O. filed a request for prelitigation panel review with the Department of Professional Licensing on March 15, 2021, with a Second Amended request filed on May 13, 2021.

b. Plaintiffs M.M., B.N., and M.O. provided each Defendant a 90-day notice of intent to commence this action on March 15, 2021, in compliance with Utah Code Ann. § 78B-3-412.

c. Plaintiffs M.M., B.N., and M.O. received a certificate of compliance from the Division of Occupational & Professional Licensing on September 9, 2021.

8. At all relevant times, Vista received Federal financial assistance and was therefore subject to the requirements of Title IX of the Education Amendments of 1971, 20 U.S.C § 1681 et seq. ("Title IX").

9. Jurisdiction is proper in this Court pursuant to Utah Code § 78A-5-102(1). This Court has jurisdiction over all Defendants pursuant to Utah Code § 78B-3-205.

10. Venue is properly before this Court pursuant to Utah Code § 78B-3-307 because the conduct complained of occurred in Salt Lake County, Utah and because known Defendants are residents of Salt Lake County, Utah.

GENERAL ALLEGATIONS

11. Ideally a child is never placed in a residential treatment facility, as typically the best place for therapeutic healing is at home with their family.

12. Relevant literature suggests a child suffering from mental illness or emotional trauma should be treated in a safe environment in the least restrictive way possible.

13. In the event that a child needs to be placed in a residential treatment facility great care should be taken to ensure that predatory tactics and behaviors are not employed.

14. That is, not only are residential treatment facilities obligated to engage in appropriate medical treatment modalities, but they are also obligated to ensure the safety and health of its residents.

15. Treatment should also be designed to avoid the institutionalization of the residents and should focus on quick and successful disengagement.

A. Operative Standards of Care for Residential Treatment Facilities

16. The standard of care for treatment at a residential facility can be determined by review of the standards set by The Joint Commission, the Utilization Review Accreditation

Commission, and/or the Commission on Accreditation of Rehabilitation Facilities, which are National Quality Programs.

17. At all relevant times, none of the Vista facilities were accredited by any of the relevant accrediting organizations.

18. At all relevant times, none of the Vista facilities had implemented the best practices developed by the accrediting organization.

19. The Joint Commission nearly universally denies certification for "boot camps" or "wilderness therapy programs," as they consistently fail to meet the quality-of-care guidelines for medically supervised care from licensed mental health professionals.

20. The American Academy of Child and Adolescent Psychiatry (AACAP) endorses the adoption of the Joint Commission standards for certification for residential facilities and provides its own supplement to those standards, which were not observed in Plaintiffs' cases.

21. The best place for children and adolescents is typically at home with their families. A child or adolescent with mental illness should be treated in the safest and least restrictive environment.

22. Due to the severity of an individual's psychiatric illness, there are times when a patient's needs cannot be met in the home or community-based setting.

23. A treating clinician should always consider less-restrictive resources before determining that a residential treatment center (RTC) is appropriate for a patient.

24. According to standards released and emphasized by the American Academy of Child and Adolescent Psychiatry and the Joint Commission, RTC staff (among other standards) should:

- Be trained in evidence-based/research-based psychosocial and other interventions,
- Be trained on and use family-centered care within the facility,

- Be appropriate for the number of patients,
- By multidisciplinary and culturally competent,
- Include a child and adolescent psychiatrist or in the case of an adolescent program, an adult psychiatrist with training in treating that age group,
- Ensure that ancillary staff has appropriate training and licensure,
- Include leadership provided by professionals with graduate level training and appropriate license and credentials who demonstrate expertise in the treatment of youth,
- Be appropriate for all acuity levels,
- Include on-site nursing care and supervision for one shift a day with on call availability for other shifts,
- Provide medical care (ill and preventive care) by a qualified primary care provider who is available 24 hours a day with hospital resources identified when necessary, and
- Require all staff to be screened with finger printing on a national level, driver's license and criminal record reviews, and a face-to-face interview to minimize the possibility of employing a predator who could endanger a child.

The admissions process should:

- Include a comprehensive evaluation prior to admission by a licensed graduate-level provider.
- Include a documented current DSM diagnosis and evidence of significant distress/impairment.
- Include a discharge plan.
- Include a medical assessment and a physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to transfer to the facility is sufficient.
- Include a review and approval of the admission by a psychiatrist for appropriateness and safety of the program.
- Identify family resources and family participation in treatment.

An initial comprehensive treatment plan must be completed within 7 days. Treatment planning

should:

- Be developed jointly with the family and youth.
- Include multidisciplinary assessments.
- Establish measurable goals and objectives.
- Be reviewed every 4 weeks.
- Include appropriate monitoring of medications.
- Include treatment modalities that are appropriate to the clinical needs of the child.
- Include the family in at least weekly therapy or, if the family lives greater than 3 hours from the facility, weekly telephone contact for family therapy must be conducted with monthly face-to-face family therapy sessions.

- Include supportive services such as religious services when requested.
- Be an extension of treatment plans formulated in previous clinical settings.

Discharge planning should:

- Begin at admission.
- Include coordination of follow-up and ongoing involvement with family and/or guardians.
- Take advantage of all community services.
- Reflect specific discharge criteria.
- Ensure that the child has a place to go at the time of discharge and that person or agency actively participated in the treatment. If a biological parent or extended family member is not available or appropriate, the designated foster parent must actively participate in the child's treatment.
- Provide families with the strategies to help their child adopt to "family life" when they return home.
- Involve coordination with community-based services to ensure a continuum of care.

To ensure RTC safety, all RTCs should:

- Have a policy that strives for a restraint-free milieu consistent with national standards and regulations.
- Review these policies with staff at least annually.
- Train all staff on effective de-escalation techniques and anger management techniques to eliminate the need for seclusion or restraint.
- Study causes of aggressive incidents and implement evidence-based techniques to prevent recurrence.
- Evaluate the patient by a medical professional or nursing staff within a timely manner after a seclusion or restraint or complaint of physical injury occurs.
- Train all staff in a protocol that includes the method to hold or contain a child who is a threat to themselves or others. The protocol must be nationally accepted and shown to be safe and not harmful to the child or staff. There is no clear indication or evidence to support use of "holding therapies." Interventions that restrict the physical movement of the child or adolescent are a form of restraint and should only be used to ensure the safety of the child and others and should not be used for punitive measures. Aversive therapies should not be used.
- Track all incidents of physical hold or restriction of movement by the facility and be reviewed periodically by the clinical and administrative staff. Treatment plans should be altered as needed.
- Refer all crimes committed by staff to local law enforcement.
- Behavior that could constitute a basis for criminal charges should be evaluated from a clinical and legal perspective. After such a review, staff should consider the appropriateness of bringing criminal charges.

RTCs should have therapeutic services standards that includes the following components:

- Licensed professionals with specific expertise in diagnoses specific to the population the RTC is serving.
- Trained in evidence-based practices.
- The child and adolescent psychiatrist's role should include attendance at multidisciplinary team meetings and treatment planning conferences, clinical supervision of other direct care personnel, involvement in therapeutic program development, and work with the clinical leadership team in monitoring the quality of care and outcomes provided at the RTC.
- When medication is used, medication monitoring will be provided by a child and adolescent psychiatrist. If a child and adolescent psychiatrist is not available to the program, a physician or other licensed prescriber with specific training and clinical experience to the population served will provide these services.
- Engagement of the child's or adolescent's family and other community supports (such as referring physicians, therapist agencies, and school systems) in all aspects of treatment.
- Treatment goals will build upon the strengths of the child or adolescent and their family and identify areas to be therapeutically addressed with specific outcomes that document progress toward those goals.

25. The Vista facilities and other named Defendants were not implementing these standards of care and were actively inflicting trauma and harm upon all Plaintiffs through their "treatment" practices, despite all of these industry standards being in place during the relevant time periods of their Vista attendance.

26. This "treatment" not only failed to help Plaintiffs with their existing conditions and concerns, but led directly to them suffering extreme pain, mental anguish, depression, and an inability to effectively treat their underlying conditions for years.

27. Upon information and belief, the therapists, staff, and clinicians at Vista engaged in practices of forced restraint and isolation.

28. Forced restraint is a practiced often employed in the "teen help" industry at wilderness programs as well as residential treatment centers.

29. Vista would often use the threat of forced restrain often.

30. Upon arrival at Vista, residents were informed that Vista staff had the power and authority to forcefully restrain those who were not cooperating or posed a flight risk.

31. Studies have shown that forced restraint, aside from presenting immediate physical risks, can be extremely traumatizing for residents and as a general matter, better alternatives are usually available.

32. Forced restrain should always be used as a last alternative.

33. Upon information and belief, Vista threatened and/or applied forced restrain in inappropriate ways causing harm to residents.

34. Vista would engage in a "point system" as a means of social and individual isolation.

35. While the "point system" has changed over time and across the Vista locations, generally it assigned point values to Vista rules.

36. In order to graduate to various "phases," a patient needed to maintain point sheets that corresponded to the residents' rule-keeping.

37. The point system dictated all levels and privileges.

38. Points could be deducted for things such as forgetting a shampoo bottle in the shower.

39. Points could be earned for things such as sitting up very quickly out of bed in view of Vista staff in the mornings.

40. Residents would have to earn points to get to a phase wherein the patient was allowed to talk.

41. For the most part, staff at Vista kept track of the resident's points.

42. Staff were not trained therapists and received no training regarding psychotherapy or other therapeutic modalities.

43. Staff were hired with only minimal qualification. There was no requirement that staff members possess advanced degrees, receive any kind of formal training in therapeutic modalities, or other relevant areas.

44. The patient's therapist would review the patient's point sheet at the end of the week to determine the patient's level or phase.

45. Level 1's were expected to maintain 75%-80% average of the available points for the week.

46. If a patient got over 85% and had no major behavioral issues, they could achieve Level 2.

47. A patient had to maintain above 90% to achieve Level 3.

48. Earning too many points, however, carried the risk of Vista staff accusing a patient of "manipulating the staff" and the patient's level would be dropped.

49. Certain special phases, such as "zero," "orientation," or "reorientation (also called "R0")", meant that a patient could not talk or make eye contact with anyone.

50. A patient on level zero or R0 would have to communicate needs, such as using the bathroom, to Vista staff using finger signs.

51. On R0, a patient was isolated to their room or the basement and could not participate in therapy sessions, school, any privileges, or speak with family.

52. While the Vista booklet given to parents maintained that R0 was a punishment for "serious offenses" such as attempting to run away, residents were actually placed on R0 for things such as carrying two mechanical pencils when only one was allowed or putting hair into a ponytail without staff permission.

53. R0 typically lasted a week.

54. However, if a patient's therapist happened to be on vacation or otherwise unavailable when a patient was supposed to be removed from R0, the patient remained on R0 until their therapist returned.

55. A patient could also be considered "off the team," wherein no other residents could look at, acknowledge, or say the name of the patient.

56. Residents considered to be "off the team" could not participate in therapy.

57. "Close" was a phase in which the patient had to wear a certain color of scrubs and had to be in arm's reach of Vista staff at all times.

58. Staff had to monitor "close" residents while they showered.

59. "Close" residents had to sleep in a closet or the hallway.

60. "Safety" was a phase in which staff would listen to the patient in the shower or bathroom.

61. "Safety" residents also slept in the closet or hallways.

62. Vista staff and therapists used the point system in a way to force compliance from residents through the use of and threat of social and sometimes physical isolation.

B. <u>The Practice of Steering Residents to Vista from Other Facilities</u>

63. Upon information and belief, Vista receives nearly all its residents as transfers and referrals from other programs or upon the recommendation of an education consultant.

64. The main programs from which Vista would receive its students were Second Nature, Evoke, and Outback wilderness programs.

65. The referring programs often have taken children from their homes unwillingly.

66. Such programs include boot-camp or wilderness-style facilities who are not certified by the relevant communities and do not employ best practices.

67. Staff and clinicians often overlap between these wilderness or boot camp facilities and Vista.

68. As a result, many residents at Vista end up away from their homes and institutionalized for many months or even years.

69. Nearly all, if not all, residents pay out-of-pocket for treatment at Vista.

70. Vista has a financial incentive to keep residents at the facility as long as possible.

71. Therapists at the wilderness programs had a duty to prioritize the medical therapeutic interests of Plaintiffs above their own financial gains.

72. Upon information and belief, therapists and counselors at other wilderness therapy programs would receive payment from Vista for referring individuals to Vista.

73. Upon information and belief, educational consultants would receive payments from Vista for referring individuals to Vista.

74. Vista would make payments to educational consultants and therapists at these programs to incentivize them to recommend Vista to their residents and to induce those same residents to enter into financial agreements with Vista.

75. Educational consultants and therapists at these programs, upon receipt of payment from Vista, would represent to the Plaintiffs and their parents and/or caregivers that additional treatment at Vista was necessary.

76. For example, a former patient-informant's therapists, Matt Hoag and Chelsie Newkirk, disclosed that therapists received significant money for referring patients to Vista and accordingly always recommended further residential treatment for all their patients following wilderness therapy.

77. Hoag and Newkirk mentioned that transition from wilderness to home life was generally difficult so transition through a residential program was always the safest path forward.

78. Notice that the educational consultant or therapist's recommendation was based, in part, on the receipt of payment from Vista for that recommendation was a material or important fact for Plaintiff's and their parents and/or caregivers to know in deciding whether to spend thousands of dollars at Vista.

79. Withholding this information from Plaintiffs and their parents and/or caregivers was tantamount to making a false or reckless statement without regard for truth.

80. Plaintiffs and their parents and/or caregivers had no way of knowing of the referral arrangement between Vista and the educational consultants or referring therapists absent disclosure from Vista or the referring therapists.

81. In the least, Vista and the educational consultants and referring therapists should have used reasonable care in making their recommendations on behalf of Vista and disclosed the referral arrangement between Vista and the referring therapists.

82. Parents and/or caregivers were not able to observe or speak with their children while they attended wilderness programs. Alternatively, referring therapists had almost daily interactions with Plaintiffs. Accordingly, parents and/or caregivers relied almost entirely on reports from the referring therapists regarding their children's progress and therapeutic needs, if any.

83. Parents and/or caregivers did not have the kind of access to Vista as educational consultants or referring therapists. Accordingly, parents and/or caregivers relied almost entirely on reports from educational consultants and referring therapists about the modalities of treatment offered at Vista and the need to apply such modalities to Plaintiffs.

84. Accordingly, the referring therapists and Vista were in the best position to observe and report on the progress of Plaintiffs and their therapeutic needs, if any and the modalities of treatment at Vista.

85. Vista the educational consultants, and the referring therapists were in the best and only position to disclose their financial arrangement and how it influenced the recommendation for further treatment at Vista.

86. Vista, the educational consultants, and the referring therapists intended plaintiffs to rely on their recommendation—devoid of disclosure of the referral arrangement between Vista and the Referring therapists.

87. Plaintiffs and their parents and/or caregivers reasonably relied on the recommendation of Vista by the educational consultants or referring therapists in deciding to send plaintiffs to Vista.

88. Their reliance on the educational consultants or therapist's recommendation was substantially due to the fact that the referral relationship between Vista and the referring therapists was never disclosed.

89. Vista the educational consultants, and the referring therapists actively concealed the referral relationship from plaintiffs and their parents and/or caregivers.

90. The referral scheme of paying educational consultants and wilderness therapy consultants for their recommendations that individuals receive treatment at Vista was developed by Vista to induce consumers into purchasing therapeutic goods from Vista.

91. Vista withheld the fact that it pays educational consultants and therapists referral monies.

92. Vista knew, or should have known, that withholding such information would induce parents and/or caregivers to purchase therapeutic goods from Vista, relying on full disclosure from Vista

93. Plaintiffs and their parents and/or caregivers suffered the loss of thousands of dollars and emotional and physical trauma as a result of this reliance.

C. INFORMANTS

a. Informant – G.M.

94. G.M. attended Vista from July 2012 through June of 2013.

95. G.M. recalls group therapy as being used to humiliate and shame other residents.

96. G.M. also recalls the point system being used to manufacture conformity from students.

97. G.M. recalls that therapy sessions would be used as an incentive to cooperate. If students were in trouble, they would withhold therapy sessions from them.

b. Informant – M.B.

98. M.B. attended Vista from October 2018 through June 2019.

99. M.B. witnessed the highly regimented lifestyle designed to create conformity.

100. She was denied medical treatment after a snowboarding accident. M.B. was told that she was being dramatic.

101. She was denied medical treatment on a separate occasion when she was experiencing sever dental pain. M.B. was told that she was using the pain as a "therapeutic distraction."

102. Ultimately, M.B. was allowed to see a dentist who indicated that her wisdom needed to be removed to relieve the pain.

103. After the procedure, M.B. was isolated and not allowed to leave the room she was set to recover in even for basic food and water needs.

c. Informant S.P.

104. S.P. attended Vista August 2012-April 2013.

105. S.P. held hands with another girl and was placed in isolation.

106. S.P. was shamed for her sexuality.

107. S.P. was told her eating disorder was "not her problem" and Vista staff would not appropriately treat it.

d. Informant R.F.

108. R.F. attended Vista Magna from January 2013-September 2013.

109. During his time at Vista, R.F. was forced to endure extended isolation.

110. R.F. was questioning his sexuality at the time and kissed another boy patient.

111. Because of this, R.F. was forced to endure isolation as a punishment, wherein he had to speak using only his fingers and had to wear ear plugs to tune out other people.

112. Vista therapists disclosed R.F.'s sexuality to his parents without his consent.

e. Informant – R.C.T.

113. R.C.T. attended Vista from January to November of 2013.

114. R.C.T. was transferred to Vista from another wilderness-based facility.

115. R.C.T's therapist at her wilderness facility recommended that R.C.T attend Vista and R.C.T.'s parents relied on this recommendation.

116. R.C.T. recalls how Vista staff and therapists would incentivize negative reporting and behavior. If one self-reported bad behavior, they would be rewarded. Residents were incentivized to humiliate and confront one-another.

117. R.C.T. recalls how one student attempted suicide and he and others in group therapy were encouraged to report that they were disappointed in her.

118. Vista treated people in such a regimented and demeaning way that it forced them to live like prisoners. Vista made it difficult to function outside of the institution.

119. Vista consistently invalidated his sexual identity and orientation. R.C.T. was encouraged to repress and hide that part of himself.

120. R.C.T.'s Vista stay cost approximately $87,000 out of pocket.

f. Informant – M.T.

121. M.T. attended Vista as a teenager in 2018-2019.

122. M.T. was transferred to Vista from Second Nature.

123. M.T. was at Vista during the time M.O. was at Vista.

124. M.T. witnessed abusive therapeutic practices used at Vista.

D. PLAINTIFFS

a. Plaintiff – M.M.

125. M.M. attended Vista at Dimple Dell in the year 2014.

126. M.M. was referred to Vista by an educational consultant.

127. M.M. was transferred to Vista from Second Nature.

128. While at Second Nature, M.M. had been violently restrained on one occasion like many other residents. The threat of such restraint was a significant source of distress for M.M. and others.

129. On her first or second day at Vista, M.M. was told by staff that they were allowed to restrain her "until you pass out" if she so much as took a step in the wrong direction.

130. On one occasion, M.M. was dropped to phase 0 for forgetting her water bottle in the classroom when the group transitioned to the kitchen. Such a small mistake resulted significant isolation and loss of privileges.

131. During her stay there were weeks where no one was allowed individual or family therapy as a group punishment.

132. On another occasion, M.M. was told to go for a walk with two boys from another treatment center so she could "learn to flirt with boys."

133. M.M. was prevented from making contact with her brother for months, and was told that once she got home she should minimize her contact with her brother so she wasn't a bad influence on him. This has severely harmed up her relationship with her sibling.

134. M.M. was told by Vista staff that she was there because her parents did not want her at home.

135. Vista forced M.M. to attend church and utilized therapy sessions to in appropriately discuss religious teachings in lieu of actually engaging in therapy.

136. M.M. was encouraged to disparage other residents by Vista staff.

137. Ryan Pepper told M.M. that she was "wrong" about childhood trauma she had disclosed.

138. Ryan Pepper consistently tried to manipulate M.M. into feeling guilty for making her parents spend money on the Vista treatment program on her behalf.

139. M.M. was told in therapeutic sessions that men only want sex, but that she would only be able to get ahead in life with a husband.

140. M.M. was told in therapeutic sessions that how women dress causes rape.

141. M.M. observed another minor patient be held in the basement for hours "for picking skin off her own fingers."

142. This patient was also violently restrained.

143. M.M. felt extreme emotional distress from witnessing the incident.

144. M.M. was forced to participate in a group activity wherein residents voted on if other residents deserved to live or die.

145. M.M.'s personal therapeutic history was revealed by Ryan Pepper during group sessions.

146. M.M. was used by Vista to monitor other residents and was required to take on a pseudo-staff-like role where she was expected to enforce Vista policies against her peers.

147. On one occasion M.M. was told by a high-level staff member that she was expected to tackle and restrain other residents in the event of a riot at the facility during a particularly tense period at the facility.

148. M.M. was kept at Vista much longer than was necessary.

149. During her time at Vista, M.M. was not allowed to explore the use of medication to help manage her insomnia, ADHD and/or depression symptoms.

150. M.M.'s Vista stay cost approximately $90,000 out of pocket.

b. <u>Plaintiff – B.N. (pronouns they/them)</u>

151. Plaintiff B.N. attended Vista from 2013—2014.

152. B.N. was referred to Vista by Derry O'Kane at Trails Carolina wilderness program.

153. B.N. was called an "attention-seeker" by therapists at Vista and was given an improper diagnosis of Obsessive-Compulsive Disorder.

154. B.N. had never complained of any symptoms of OCD but was accused of manipulating others into thinking she had OCD.

155. B.N. was given severe food restrictions by the therapist after the therapist had commented on B.N.'s weight.

156. B.N. has a nervous habit of twirling their hair. B.N. was punished for twirling their hair by forced isolation.

157. B.N. attempted suicide with a fork out of desperation due to the conditions at Vista.

158. B.N. was admitted to a hospital, but Vista staff did not permit doctors to speak to B.N. alone, despite the doctors requesting it.

159. B.N. was moved to R0 level after the suicide attempt.

160. B.N. had to apologize to other patients and staff for "manipulation" after the suicide attempt.

161. B.N. remained on R0 the last four months of their stay.

162. B.N. was not permitted to communicate with anyone.

163. B.N. self-mutilated with an electric razor.

164. Despite serious injury, Vista staff did not take B.N. to the hospital; instead, Vista staff merely poured rubbing alcohol on the wounds even though they required stitches.

165. Vista staff lied about the severity of B.N.'s injuries to B.N.'s parents.

166. As a result of isolation and emotional abuse, B.N. attempted suicide by trying to jump off a balcony but was stopped by Vista staff. As a result, B.N. was "discharged" from the program.

167. Vista staff told B.N.'s parents that B.N. had refused to participate. In actuality, the therapist would not allow B.N. into the sessions because they were at level zero/R0.

168. B.N.'s Vista stay cost approximately $100,000.

c. Plaintiff – R.P.

169. R.P. attended Vista at Dimple Dell from April 2008—January of 2009.

170. R.P.'s Vista stay cost approximately $95,000 out of pocket.

171. R.P. was referred to Vista by an educational consultant.

172. Upon arrival at a Vista, R.P. was strip searched. R.P recalls feeling like a prisoner not a student or resident.

173. Upon information and belief, all residents were strip searched upon entering Vista and were periodically strip searched from time to time.

174. Upon information and belief, during the relevant time period, Vista engaged in a "levels" system where privileges were awarded and taken away based on behavior.

175. When a minor was brought to Vista and broke any rule, they were given level "re-orientation," or later termed level "zero," in which minors were not permitted to communicate with or look anyone in the eye for a minimum of five days.

176. Placing a resident at level zero was a means of socially and sometimes physically isolating the individual.

177. While R.P. was in level zero, her therapist and clinical director Ryan Pepper would not hold sessions with her and told her "how disappointed in [her] [he was]."

178. R.P. was forced to "write down [her] secrets" which had to be shared with the group at large during "group therapy sessions."

179. If a minor did not have a secret to share, they were told they were lying. If there was a secret to share, the therapists would engage in shaming, or expect the minor patient to cry to "show [they] cared" about what they had done.

180. R.P. told Ryan Pepper that she had feelings for another girl. In response, Pepper told her numerous times he would give her a "special assignment" wherein he would take her to a

shopping mall, and she had to flirt with three boys enough that they would give her their phone number.

181. Ryan Pepper later took R.P. to tour the charter school "Paradigm Academy," during which time he assigned R.P. to ask three boys how they liked school. R.P was not allowed to speak to any of the girls.

182. Pepper told R.P. that she was "not sexual enough."

183. R.P recalls staff members and therapists being particularly focused on female residents' sexuality and sexual behavior.

184. R.P. observed an incident wherein another Vista patient was "treated."

185. The girl was at Vista for eating disorders but had also been raped when she was twelve years old.

186. The patient did not want to discuss her rape, but Ryan Pepper and another therapist surrounded the girl, made fun of her, impersonated her rapists, and forced her to state the name of her rapists.

187. R.P. suffered extreme emotional distress from witnessing the incident.

188. Upon information and belief, as part of the point system, residents were encouraged by therapists to shame other residents for their "secrets" or actions.

189. Residents were encouraged to act out against other residents in group therapy.

190. Vista staff and providers would leverage the group dynamic in an effort to shame, ridicule, humiliate, and alienate residents.

191. R.P. was publicly shamed for her sexuality and accused with lying about it by another patient at the encouragement of a therapist.

192. When R.P. stated that the shaming had hurt her feelings, the therapists disallowed her from participating in a future activity because she was "too sensitive."

193. Vista staff and providers would shame, humiliate, and emotionally isolate R.P. as part of her "treatment."

d. Plaintiff – A.A.

194. A.A. attended Vista at Dimple Dell from September 2008 to August 2009.

195. A.A. was referred to Vista by an education consultant.

196. A.A. was promised that she would only be at Vista for a couple months, this was not the case.

197. A.A. was deprived of all her belongings and privacy while at Vista.

198. A.A. was told by therapy staff workers that she "acted like a princess, like Paris Hilton."

199. A.A. was forced to wear a plastic crown and carry a plastic wand.

200. Ryan Pepper told A.A. that "[she] was so perfect that [she didn't] fart." Ryan Pepper forced A.A. "to fart in front of the group" at a therapy session and had everyone comment on how loud and smelly it was.

201. Later, Ryan Pepper forced A.A. to defecate in her underwear and show it to him.

202. During another group therapy session, A.A. was forced to get on all-fours in the center of the group to be "treated like a dog." Other group members were encouraged to walk over to her and push her over, to which A.A. had to say, "thank you, may I have another?"

203. A.A. witnessed another Vista patient be given a fly swatter, with which she was forced to hit herself when she had a negative thought.

204. During another group therapy session, A.A.'s therapist told her she was a bad person. Everyone in the group then had to tell A.A. that she was a bad person.

205. A.A. was labeled by staff as "vain" and they required her to "rat" out her hair, did not allow her to shower, and forced her to wear dirty clothing.

206. Ryan Pepper told A.A. that he had "re-virginized" her.

e. Plaintiff – P.D.

207. P.D. attended Vista from February 2008 to May 2009.

208. P.D. was referred to Vista by an education consultant.

209. P.D. was degraded as part of her "treatment" and told that masturbation and premarital sex was wrong. However, in her sessions with Ryan Pepper, he would ask if she had been promiscuous and would be awarded more "points" if she made sexual references during group therapy sessions.

210. In one group session, Pepper encouraged all residents to share their "secrets," and they were congratulated if they "said something horrible." If she did not have a secret to share, she was punished. The group was encouraged to "rat out" their friends for more points.

211. P.D. food intake was monitored. She mentioned to her Vista treating physician, Dr. Jeff Kovnick, that she had a desire to lose weight.

212. She was placed on a medication that had weight loss as a byproduct and was told "not to tell anyone."

213. P.D. believes she was overmedicated while at Vista, contrary to the prior prescriptions she was given before Vista. She was placed on four medications while at Vista that were not medically necessary.

214. Vista forced P.D. to undergo significant dental work with no anesthetic, subjecting her to severe physical pain.

215. P.D. has since attempted to request her medical records from Vista several times and has not gotten any response from Vista.

f. Informant – M.L.

216. M.L. attended Vista from August 2012 until June of 2013.

217. M.L. was referred to Vista by an education consultant.

218. Upon arrival at Vista M.L. was subjected to a strip search.

219. She was sent to Second Nature for a period of time then sent back to Vista.

220. M.L. was forced to engage in harmful group therapy and was at times denied medical treatment.

221. M.L. was forced to endure isolation for two weeks in which she was not allowed to communicate with or look at anyone. This was due to her being put at level zero.

222. Vista therapists switched M.L.'s medications so recklessly that she got serotonin syndrome.

223. Vista professionals would not treat her serotonin syndrome.

224. M.L's Vista stay cost approximately $150,000 out of pocket.

g. Plaintiff – A.B.

225. A.B. attended Vista in 2009 and 2010.

226. A.B. attended Viewpoint Center treatment program before Vista.

227. A.B was referred to Vista by her therapist at Viewpoint Center.

228. A.B. did not need additional treatment when she was referred to Vista.

229. She recalls while at Vista that staff and therapists would leverage isolation tactics and group humiliation in order to make people conform.

230. While at Vista she would have to ask for permission to speak to others.

231. While at Vista group meetings would often consist of point out and criticizing others behavior in an effort to shame people into conformity.

232. At one point, A.B. was in such emotional pain that she ran away from the facility. She did not have shoes at the time given restrictions and so ran away in socks. She was found three hours later at a gas station.

h. Plaintiff – M.K

233. M.K. attended Vista Magna in the year 2008, which did not become a male-only treatment facility until 2014.

234. M.K.'s therapist told M.K.'s parents that she needed additional treatment and referred them to Vista.

235. Relying on her therapist's recommendation, M.K.'s parents ultimately had her transferred to Vista from Second Nature Oregon.

236. M.K. did not need additional therapy.

237. M.K.'s Vista stay cost approximately $125,000 out of pocket.

238. M.K. was banned from speaking to her parents or other family members for several weeks in the beginning of her Vista treatment.

239. During these periods, M.K. was also forbidden to speak in any capacity outside of therapy sessions.

240. M.K. was a rape survivor before coming to Vista.

241. During "therapy" sessions, M.K. was forced to give the details of her rape and discuss how she "contributed to the rape."

242. M.K. was forced to rewrite the story of her rape over a dozen times when Vista staff requested "more details."

243. If M.K. was accused of having left out any details, she was accused of lying and fabricating the rape.

244. Vista staff sent all M.K.'s written versions of her rape to her parents.

245. M.K. was improperly prescribed medications by the treating physician at Vista.

246. M.K. had very negative reactions to the medications that were prescribed at Vista, including exhaustion, lethargy, and extreme weight gain.

247. M.K. told her therapist at Vista that she was uncomfortable around males. As a result, her therapist made her join the male groups within Vista and attend male functions.

248. At one point, M.K. expressed that she did not get along with another girl patient at Vista. M.K. was forced to be tied together with the girl by a two-foot string for over a month, wherein they had to engage in every single activity together, including usage of the bathroom.

249. M.K. witnessed physical violence against other residents at Vista, including forced sedation.

i. Plaintiff – E.S.

250. E.S. attended Vista Magna in 2008.

251. E.S. was referred to Vista by her therapist at Second Nature, Jason Capel.

252. Jason Capel was married to Bobbi Carter, a therapist at Vista.

253. E.S. was prescribed by her treating physician at Vista a number of medications she does not believe were medically necessary and that had severely negative side-effects, including weight gain.

254. When E.S. gained weight, she was "punished" by Vista staff, including being made to exercise multiple times a day and withholding food from her.

255. Vista staff told E.S. that she "took no pride in [her] looks," and took her to buy nicer clothing and to get her hair done. However, once she returned from said outing, Vista staff made a spectacle of her by asking other residents if they were "jealous" of her and asking if they were "mad at [E.S.]" because of her new look. E.S.'s self-worth and relationships with fellow residents were severely affected.

256. Vista staff confiscated all of E.S.'s personal items, including her photographs of family and friends. E.S. attempted to get into a room that contained these items, and was physically restrained by four Vista staff, who injected her with something to sedate her against her will.

257. For the following month, E.S. was placed at level zero, where she was not allowed to sit on chairs, and could not communicate with anyone except by gesturing with her fingers.

258. In December of 2008, E.S. attempted to "get away" by hiding out in a bathroom. Vista staff again physically restrained her and injected her with a sedative against her will.

259. Toward the end of her time at the program, E.S. was forced to write down all the ways that "Vista had rehabilitated [her]" and regurgitate terms staff had told her. Nothing she wrote down was true, but she felt forced to say those things in order to graduate and escape Vista.

260. Vista staff threatened to send E.S. back to wilderness therapy for a third time if she did not accept an intravenous sedative.

j. <u>Plaintiff – A.J.</u>

261. A.J. attended Vista at Dimple Dell in 2012 and 2014.

262. A.J.'s therapist, Coady Scheuler told A.J.'s parents that she needed additional treatment and referred them to Vista.

263. Relying on Ms. Scheuler's recommendation, A.J.'s parents ultimately had her transferred to Vista from Second Nature.

264. A.J. did not need additional therapy.

265. A.J.'s Vista stay cost approximately $200,000 out of pocket.

266. During her time at Vista, A.J. was prescribed over five medications that were immediately unprescribed by subsequent prescribing physicians after her time at Vista.

267. A.J. suffered from constipation. A.J was forced to carry a "bathroom journal" wherein she had to give detailed descriptions of her bowel movements that was then shared with all the staff and other residents.

268. A.J. ran away twice from Vista. When she returned to Vista, she was "not allowed" to talk about her experiences when she ran away and was forced to sleep in the living room.

269. A.J. was friends with another female Vista patient. That female was in a romantic relationship with another female at Vista. A Vista staff member knew about the relationship and stated that he would not tell anyone about their romantic involvement if they "hooked up" and let him watch.

270. A.J. had to endure many inappropriate and sexually harassing comments from male Vista staff, including commenting on her looks and prior sexual activity.

k. <u>Plaintiff – C.F.</u>

271. C.F. attended Vista Magna in the year 2011.

272. C.F.'s prior therapist told C.F.'s parents that she needed additional treatment and referred them to Vista.

273. Relying on C.F.'s therapist's recommendation, C.F.'s parents ultimately had her transferred to Vista from her prior program.

274. C.F. and her parents were promised that Vista was like a boarding school and that she would have consistent and frequent contact with her parents. This was not true as most residents were not allowed to have such contact with their parents.

275. C.F. was extremely isolated at Vista and was forced to sleep in the living room on a sheet with staff watching.

276. C.F's letters and phone calls were monitored by staff.

277. School was self-taught and the same curriculum applied to everyone, regardless of age or ability.

278. C.F. had mental health medication that had been prescribed to her prior to attending Vista. A therapist at Vista diagnosed C.F. with a psychotic disorder and improperly altered the levels of her medication.

279. C.F. has lasting trauma and frequent nightmares from her time at Vista.

l. Plaintiff – M.E.M

280. M.E.M. attended Vista at Dimple Dell from April 2012 until March 2013.

281. M.E.M.'s prior therapist told M.E.M.'s parents that she needed additional treatment and referred them to Vista.

282. Relying on M.E.M's recommendation, M.E.M.'s parents ultimately had her transferred to Vista from Second Nature.

283. M.E.M. did not need additional therapy.

284. M.E.M. was a victim of child sexual abuse prior to her stay at Vista by her stepbrother.

285. Ryan Pepper told M.E.M. that the sexual abuse was "not a big deal" and that M.E.M. was "attention-seeking."

286. Pepper told her that she needed to repair the relationship with her stepbrother.

287. M.E.M. is sexually attracted to females. Ryan Pepper told her that she was not actually attracted to females.

288. When M.E.M. was discovered to have kissed another girl, she was dropped to level zero where she was not allowed to communicate with anyone and had to alert staff of any of her needs "by using [her] fingers." Ryan Pepper told her that she could get arrested for kissing another girl.

289. As a result of her time at Vista, M.E.M. continues to suffer severe and persistent trauma with physical manifestations.

m. Plaintiff – J.H.

290. J.H. attended Vista at Dimple Dell from February of 2008 to June of 2009.

291. J.H.'s prior therapist, Vaughn Heath, told J.H.'s parents that she needed additional treatment and referred them to Vista.

292. Relying on Mr. Heath's recommendation, J.H.'s parents ultimately had her transferred to Vista from Second Nature.

293. J.H. did not need additional therapy.

294. On the plane ride to Vista after a home visit, J.H. was sexually assaulted by a man sitting next to her.

295. J.H., a minor at the time, notified Vista of the sexual assault upon her arrival.

296. Vista staff failed to report the sexual assault, as was their legal obligation, even though they had contact information of the man who sexually assaulted J.H.

297. Ryan Pepper, in therapy sessions and otherwise, told J.H. that she was "sexually promiscuous."

298. Ryan Pepper made J.H. "examine [her] role" in the sexual assault.

299. Ryan Pepper told J.H. that the sexual assault was her fault and that she had broken Vista rules by engaging in sexual activity.

300. J.H. was moved to "close" phase, wherein she could not communicate or make eye contact with anyone as a result of being sexually assaulted.

301. When referring to J.H. at that time, other patients had to call her "close."

302. Ryan Pepper's and Vista's treatment of J.H. after her sexual assault was consistent with Vista's treatment of sexually assaulted patients generally—Vista habitually blamed, shamed, and further traumatized any patient that disclosed a sexual assault.

303. During her stay at Vista, J.H. observed and was subjected to sleep deprivation, unnecessary dietary restrictions, and humiliation tactics as part of "treatment."

304. In group therapy sessions, residents would have to go around and say a derogatory thing about everyone else in the circle.

305. Some residents were subjected to a consequence or punishment wherein they would be required to say "I am a liar but I am about to tell the truth" before every sentence they spoke, both in group therapy settings and in everyday life.

306. J.H. witnessed another patient, whom the staff had labeled as "vain" be required to "rat" out her hair, was not allowed to shower, was forced to wear dirty clothing, and whose hygiene got so bad as a result that it was medically necessary to cut her hair because of resulting sores on her head.

307. J.H. had questions about her gender identity at the time she attended Vista. Ryan Pepper would use religious teachings to attempt to convince her that she wasn't a trans person.

308. Ryan Pepper forced J.H. to dress overtly feminine and to shower in front of female therapists.

n. <u>Plaintiff – D.H. (pronouns they/them)</u>

309. D.H. attended Vista at Dimple Dell from 2008—2009.

310. D.H.'s prior therapist, Vaughn Heath, told D.H.'s parents that they needed additional treatment and referred them to Vista.

311. Relying on Mr. Heath's recommendation, D.H.'s parents ultimately had them transferred to Vista from Second Nature.

312. D.H. did not need additional therapy, nor were other alternative treatment options presented for consideration to D.H.'s parents.

313. D.H.'s Vista stay cost approximately $50,000 out of pocket.

314. D.H. experienced a culture of shame at Vista wherein residents were incentivized to tattle on themselves or others and were punished if they did not.

315. D.H. was subjected to heavy religious influence and was told that drugs, sex, masturbation and coffee were bad.

316. D.H. once described a dream in a therapy session they had wherein they had been sexually molested by their father.

317. D.H. made it clear that it had not actually happened and was just a dream. However, Ryan Pepper brought up the dream during a family therapy session while D.H.'s parents were visiting. Pepper stated that there was truth to the dream and that they all needed to think about if D.H's father had sexually abused D.H. .

318. During therapy sessions, D.H. had to discuss sexual experiences and had to say that they were promiscuous.

319. D.H. was not allowed to see a doctor, even when they had persistent medical issues. D.H. required an antibiotic that had to be taken with food.

320. D.H's parents had to call Ryan Pepper to give permission to authorize the medication.

321. Pepper told D.H.'s parents that D.H. was being manipulative to get food and medications.

322. D.H. witnessed "interventions" given to other residents wherein they were forced to tell intimate details of prior sexual assaults.

323. D.H. remembers one such intervention of another patient where she had to get in the middle of the group so the other residents could physically push her around and call her a "slut" and a "whore."

324. D.H. witnessed another patient (A.A.) be told that she was "entitled" and "too pristine," and as a result Ryan Pepper required her to defecate in her pants and show it to him before she would be allowed to receive packages that had been sent to her. D.H. was severely traumatized by this observation.

o. Plaintiff – B.M. (pronouns they/them)

325. B.M.'s therapist told B.M.'s parents that they needed additional treatment and referred them to Vista.

326. Relying on B.M.'s recommendation, B.M.'s parents ultimately had them transferred to Vista from Second Nature.

327. B.M. did not need additional therapy.

328. While at Vista, staff and others would often use tactics of physical restraint, social and physical isolation, and public humiliation as a means of promoting conformity.

329. B.M. was often forced to eat and sleep alone and was denied educational opportunities.

330. B.M. was forced to discuss and disclose prior trauma sources in an effort to get B.M. to feel vulnerable.

331. The severe physical and emotional strain placed on B.M. ultimately led to B.M. engaging in self-harm and other abusive practices.

332. B.M.'s journals were searched by Vista staff and were later used by staff as leverage to humiliate B.M. during group therapy sessions.

p. Plaintiff – E.P.

333. E.P. attended Vista in 2006.

334. E.P. was transferred to Vista from a treatment facility in L.A. called Visions.

335. E.P.'s prior therapist, in conjunction with an educational consultant named Teri Solocheck, recommended she attend Vista and E.P.'s parents relied on that recommendation.

336. E.P. did not need additional therapy.

337. E.P. recalls being strip searched while at Vista as a means of humiliating and inducing conformity.

338. She was often asked to participate in humiliation tactics against other students.

339. If students had issues with each other, they would tie the two students together with a rope in an effort to force them to "get along."

340. E.P.'s stay at Vista cost approximately $100,000.

q. Plaintiff – E.E.

341. Informant E.E. attended Vista from September of 2014 until May of 2015.

342. E.E.'s prior therapist, Cody, told E.E.'s parents that they needed additional treatment and referred them to Vista.

343. Relying on Cody's recommendation, E.E.'s parents ultimately had them transferred to Vista from Second Nature.

344. E.E. did not need additional therapy.

345. She recalls being forced to share prior sexual trauma in group therapy even though she did not want to relive that experience. This caused her further trauma.

346. E.E. later heard rumors of a male staff member exchanging nude photos with underage residents at Vista.

347. E.E. witnessed staff and therapists using group therapy as a means of humiliation and isolation against students.

348. E.E.'s Vista stay cost approximately $90,000.

r. Plaintiff – E.A.

349. E.A. attended Vista from March through August of 2019.

350. E.A.'s prior therapist, Trina Grater, told E.A.'s parents that she needed additional treatment and referred them to Vista.

351. Relying on Ms. Grater's recommendation, E.A.'s parents ultimately had her transferred to Vista from Evoke.

352. E.A. did not need additional therapy.

353. During her time at Vista, E.A. recalls being asked to participate in an "accountability circle." During this time a single student would be placed in the center of the circle, and everyone would attack and humiliate the student in the middle. Vista staff would constantly force students to humiliate and degrade others.

354. Consistent with how Ryan Pepper and other Vista staff treated victims of sexual abuse, Ryan Pepper forced E.A. to talk about "her part" that she played in her former sexual abuse by her father.

355. Ryan Pepper told E.A. that she couldn't have been sexually abused by her father because he "seemed like a nice guy."

356. Ryan Pepper told E.A. that she could not be a lesbian because she had dated a boy before.

357. Vista staff put E.A. on unnecessary medications that made her extremely lethargic, caused significant weight gain, and made her depressed.

358. At Vista, E.A. was forced to participate in a dance class that was overtly sexual in nature. When E.A. stated she was uncomfortable and did not want to participate, Vista staff told her she had no choice.

359. Staff at Vista often spoke to E.A. about M.O. Staff told E.A. that M.O. was a bad influence and that she should stay away from her. E.A. felt that they were deliberately trying to ostracize, isolate, and humiliate M.O.

s. Plaintiff – K.E.

360. K.E. attended Vista from 2003 to 2005.

361. K.E.'s prior therapist, Vaugh Heath, told K.E.'s parents that she needed additional treatment and referred them to Vista.

362. Relying on K.E.'s therapist's recommendation, K.E.'s parents ultimately had her transferred to Vista from Second Nature.

363. K.E. did not need additional therapy.

364. While at Vista K.E. was forced to participate in "spotlight" exercises where people would be put in the middle of a circle and told about how awful they were.

365. K.E. witnessed how Vista would pit other students against each other and try to create an atmosphere of fear and conformity.

366. K.E. observed how Vista staff and therapists would use the "level" system to create an atmosphere of fear and conformity.

t. Plaintiff – K.G.

367. K.G. attended Vista from June of 2013 through March of 2014.

368. K.G. was referred to Vista from a separate facility by the name of Outback Wilderness. After going to Outback, K.G. was referred to Vista by therapists at Outback and an educational consultant.

369. K.G. estimates that her parents pent approximately $90,000 for her treatment at Vista.

370. K.G. had suffered a prior sexual assault trauma that was not treated properly at Vista.

371. K.G. was forced to share and relive her traumatic events in group settings.

372. During her time at Vista, K.G. was isolated, degraded, and forced into hostile confrontations with other students.

373. On one occasion, K.G. recalls Vista staff and therapists forcing another student to hold a funeral for her aborted fetus.

u. Plaintiff – K.S.

374. K.S. attended Vista from March 2008 to December 2008.

375. K.S. was referred to Vista from Second Nature.

376. While at Vista, K.S. was forced to submit to an STD screen. She was told she had HIV.

377. At this point, K.S. had not had any sexual relationships with anyone.

378. Staff and therapists forced her to admit in a group therapy setting that she had sex or had been raped.

379. A few days later the test was rerun, and she was negative for HIV. K.S. was accused of manipulating the group by admitting to sexual intercourse and was then forced into isolation.

380. K.S. witnessed how the level system was used to manipulate and ostracize students. People would lose "privileges" to speak, sit on furniture, place telephone calls.

v. Plaintiff – N.W.

381. N.W. attended Vista from September 2018 to August 2019.

382. N.W. was referred to Vista from Elements wilderness.

383. N.W.'s therapist at Elements recommended she attend Vista and N.W.'s parents relied on that recommendation in sending her to Vista.

384. N.W. witnessed the use of group therapy to encourage students to tell on each other and alienate others who were not participating.

385. The levels system encouraged students to engage in therapy even if they didn't want to or did not feel comfortable doing so. This created an environment of fear.

w. Plaintiff – R.G. (pronouns they/them)

386. R.G. was at Vista November 2018 through August 2019.

387. R.G. was transferred to Vista from Second Nature wilderness program.

388. R.G.'s therapist at Second Nature recommended that R.G. attend Vista and R.G.'s parents relied on this recommendation.

389. R.G. recalls the use of group therapy as a means telling on other students in an effort to shame, humiliate, and create fear.

390. Vista refused to properly medically treat R.G. when R.G. hit their head and had a concussion.

391. R.G. confided in their therapist, Ryan Pepper, about their sexuality and the fact that they were homosexual. Pepper told them that they were confused.

392. Vista staff and others took measures to emphasize R.G.'s sexuality as a survivor of sexual assault and would slut-shame them for how they dressed and presented themselves.

x. Plaintiff R.B.

393. R.B. attended Vista at Dimple Dell from June 2006-April 2007.

394. Prior to attending Vista, R.B. was a patient at John Dewey Academy, Elan School, and Second Nature Wilderness Therapy.

395. R.B. first heard about Vista while a patient at Second Nature.

396. R.B.'s therapist at Second Nature recommended she go to Vista and her parents relied on that recommendation.

397. R.B. stated that Second Nature, or a similar wilderness therapy program, routinely funneled residents to Vista.

398. R.B.'s therapist told her she was lying about past abuse and refused to treat her for it.

399. R.B. was forced to chart her bowel movements.

400. R.B. had to describe in detail her fecal matter and staff had to monitor it.

401. R.B. previously had a valid prescription for Adderall, which Vista staff would not give to her.

402. R.B.'s father had to get involved to ensure that R.B. was given appropriate medication while at Vista.

403. R.B. was encouraged, through Vista's point system, to disclose other residents' "misdeeds."

404. Vista staff ridiculed R.B. for keeping kosher and other aspects of her religion.

405. R.B. once told her parents that she was unhappy at Vista. After doing so, R.B. was put in isolation, in which she was not allowed to make eye contact with anyone and had to communicate through raising her hand.

406. While in isolation, R.B. had to lie on the floor while others did schoolwork.

407. Other residents were instructed not to speak to R.B. for one week.

408. Vista staff forced R.B. to be tied to two other residents for two weeks by a rope.

409. Among other sever issues, being tied to other residents by a rope prevented her from going to temple to religiously worship.

410. While a patient at Vista, R.B. heard that another patient, V.P., was sexually assaulted while living with a staff member on "day treatment."

411. A Vista staff member's husband had sexually assaulted V.P.

412. R.B., and other Vista residents, were told to ignore V.P. and were not allowed to ask about her, speak to her, or speak about the situation at all.

413. Vista's treatment of V.P., witnessed by R.B., was consistent with Vista practices of blaming, shaming, and isolating victims of sexual assault.

414. V.P. was kept on isolation, stopped eating food, and lost an extreme amount of weight.

415. R.B.'s stay at Vista cost approximately $100,000.

y. Plaintiff S.E.

416. S.E. attended Vista Magna (when it was co-ed) from August 2009-June 2010.

417. S.E.'s prior therapist, Jason Capel, told S.E.'s parents that she needed additional treatment and referred them to Vista.

418. Relying on Mr. Capel's recommendation, S.E.'s parents ultimately had her transferred to Vista from Second Nature.

419. S.E. did not need additional therapy.

420. S.E.'s Vista stay cost approximately $110,000 out of pocket

421. S.E. first attended Second Nature, where she was told by Second Nature staff that the "kids we like the most" get referred to Vista.

422. S.E.'s therapist at Second Nature, Jason Capel, was married to Bobbi Carter, a practicing therapist at Vista.

423. Jason Capel told S.E. that she was referred to Vista because she was "special."

424. S.E. pointed this relationship out as a potential conflict of interest and was punished by Bobbi Carter.

425. During her time at Vista, S.E. was forced to endure isolation wherein she could only communicate with her fingers, could not make eye contact with others, and had to sit in front of a concrete wall.

426. During isolation, S.E. was not allowed to attend school or read.

427. At Vista, S.E. was prescribed many medications that were not medically necessary and had not been prescribed to her before Vista, including Buspar, Lithium, and Abilify.

428. S.E. has had negative physical side-effects from these unnecessary medications.

429. S.E. stated that there is a "kickback" between Second Nature and Vista and residents are recommended to Vista unethically and solely for money.

430. S.E.'s Vista stay cost approximately $100,000 out of pocket.

z. <u>Plaintiff – M.O.</u>

431. M.O. began attending Vista at the Dimple Dell location in September 2018 when she was 17 years old.

432. While at Vista M.O. was severely overmedicated and sedated.

433. While at Vista, M.O.'s therapist would rank her residents and told M.O. that she was her least favorite patient.

434. On occasion, Vista would deny M.O. therapy for being "too dramatic" or "annoying."

435. M.O. recalls the environment at Vista to be particularly sexualized where flirtations and grooming often occurred.

436. On one occasion, M.O. recalls a history teacher at Vista taking a picture of his erect penis in front of M.O. and sent it to someone on his phone. M.O. believe he intentionally made sure that M.O. saw and was aware that he was sexting with someone.

437. David Joshua Moore ("Moore"), a staff member employed by Vista, saw M.O. distressed and told her that he "liked her," "wanted to be [her] friend," and thought she was "amazing."

438. M.O. had previously been sexually victimized. As a result, she was particularly vulnerable to sexual grooming and predation.

439. The methods of isolation and ostracization made M.O. particularly susceptible to sexual grooming.

440. Moore began to sexually groom M.O. by frequent communication discussing "breaking barriers" between them, going on trips together just the two of them, revealing intimate details of his prior romantic relationships, telling "secrets," and recurrent private time together.

441. Moore would show her pictures of property he was planning to buy for the two of them to move to once she graduated.

442. Moore told M.O. that if she told anyone about the relationship he was developing with her, he would have to leave Vista, he would lose his EMT license, he could not be a private military contractor, and he would kill himself.

443. Prior to M.O.'s arrival at Vista, a staff member had warned superiors and directors of Moore's inappropriate contact and flirtations with another student (a 14-year-old) at Vista.

444. This staff member noted that Moore had been acting inappropriately with another female student at Vista.

445. Despite this warning and being on notice that Moore was willing to engage in inappropriate behavior and form inappropriate relationships with female students and residents at Vista, upon information and belief, no steps were taken to discipline Moore or protect other students like M.O.

446. M.O. was afraid to tell anyone at Vista about Moore's abuse, but staff members at Vista began to communicate with M.O. and Moore about how their relationship was "inappropriate" based on observations of M.O. and Moore spending time together. Other residents/students at Vista would tease M.O. about Moore's attention to her.

447. Moore, Vista staff, and therapists worked to ostracize M.O. from her peers.

448. Staff members, aware of the relationship between Moore and M.O., told Moore to stay away from M.O., but Moore was able to make free and consistent contact with M.O.

449. Even upon suspicion of now the second inappropriate relationship Moore had fostered with an underage student and resident at Vista, upon information and belief, none of the Defendants took any steps to protect M.O. from Moore's predation.

450. Defendants labeled M.O. as a "provocateur."

451. Moore began to tell M.O. that he "loved" her, and that they were "in a relationship."

452. Moore told M.O. to keep their "secret" hidden from the Vista therapists. Moore told M.O. that it was "us against the world," "like Bonnie and Clyde," and that life was not worth living without her.

453. Moore would write letters to M.O. in which he told her he loved her. Moore would take the letters back.

454. Moore offered M.O. a locket, but M.O. did not accept it.

455. Sometime in the fall of 2018, M.O. and Moore attended a movie together. M.O. was wearing a skirt and Moore touched her upper thigh with his hand.

456. Sometime in the winter of 2018, M.O. and Moore attended another movie together. M.O. was wearing a dress and Moore digitally penetrated M.O. inside her vagina.

457. During a Harry Potter themed party, R.G. was aware that Moore had digitally penetrated M.O. while in the back of a van.

458. Around New Year's Eve of 2018, M.O. and Moore were sitting in a van together. Moore began to touch and kiss M.O., digitally penetrated her again, and tried to get M.O. to touch him, saying "you're hot," he was "turned on," and asking that she "check [his crotch] out." M.O. tried to touch him for a few seconds but then stopped and pulled away.

459. Upon information and belief, another patient of Vista approached M.O. and stated that Moore had done the same thing to her.

460. One fellow student at Vista "kept watch" for M.O. and Moore while Moore sexually assaulted M.O.

461. On New Year's Day, 2019, two other Vista residents told staff members about having seen Moore and M.O engage in physical interactions.

462. Vista staff member and therapist Toni Mazzaglia confronted M.O., telling her she was "lucky [she wasn't] kicking [her] out of the program." M.O., under the severe manipulation of sexual grooming, stated that she and Moore were in love.

463. Following the disclosure of Moore and M.O. physical interactions, upon information and belief, Pepper met with Moore and told Mazzaglia that Moore wasn't a bad guy and that he was sad inside.

464. Mazzaglia asked M.O. if anything physical had happened with Moore before her 18th birthday. M.O., at the time wanting to protect her abuser who was in a position of special trust over her, had thoroughly groomed her, and threatened her not to tell anyone, stated that nothing physical had happened prior to her turning 18.

465. That was not true and in fact, Moore had sexually assaulted M.O. prior to her turning 18.

466. M.O. was enticed and coerced into participating by a person in a position of special trust and was unable to appraise the nature of the act or the consequences to her health and safety.[3]

467. Mazzaglia asked M.O. for her journal, which had details of the physical relationship with Moore, which she confiscated and kept.

468. Upon information and belief, at some point between January 2019 and June 2019 Moore was let go from Vista.

469. M.O. had to attend "accountability sessions" every day for a few weeks afterward at Vista, in which other residents and staff members blamed her for Moore's firing, told her she "did something horrible," that M.O. had ruined the other girls' therapy, that because of M.O. "the only cool staff member" at Vista had been fired, and M.O. felt "horrible and ashamed."

470. Vista therapists encouraged other patients to bully M.O.

471. After the "accountability sessions," everyone at Vista were "forbidden" to speak of what happened between Moore and M.O. Law enforcement was never notified.

472. M.O. tried to speak with Ryan Pepper, the clinical director of Vista at Dimple Dell. Pepper ignored M.O. and instead communicated through Mazzaglia, who told M.O. that Pepper stated that Moore "seems like not a bad guy" and "was not a predator," after having a one-on-one meeting with Moore.

473. M.O. graduated from Vista on June 7, 2019, after which M.O. asked Mazzaglia for her confiscated journal. Mazzaglia told M.O. that she had read the journal and that the "contents disturbed [her] so much that [she] had to burn it."

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[3] *See* U.C.A. 76-5-406.

474. Consistent with Vista's treatment of patients who had been sexually assaulted, Vista blamed M.O. for Moore's sexual abuse of her.

475. The abuse of M.O. by Moore and the deliberate indifference, coverup, institutional betrayal and retaliation against M.O. by appropriate persons and Vista deprived M.O. of equal access to educational benefits and caused her to have severe and lasting trauma and physical manifestations of such trauma.

476. M.B. recalls that after Moore was fired, M.O. was forced to apologize to others at Vista in a group setting for getting Moore fired.

477. After Moore was fired, M.T. recalls being encouraged as part of group therapy to shame M.O. and talk about how Moore was a good person and that M.O.'s behavior caused Moore to get fired.

478. R.G. recalls that after Moore was terminated, staff and therapists—including Pepper and Mazzaglia—made M.O. sit on a table in the middle of other residents as part of group therapy.

479. During this session, M.O. was blamed for Moore's termination in front of other residents and clients.

480. M.T. recalls some Vista residents indicating that they felt unsafe after Moore was fired and were angry with M.O.

481. M.T. recalls at a different time attending a staff meeting of sorts (as she was on "close" at the time) and staff members telling Moore to be careful because of how things "looked" with M.O. and that his behavior could ruin his career; indicating that staff was aware of that Moore was grooming M.O.

482. Vista staff and others communicated that it was M.O.'s fault that she had been assaulted and that Moore had lost his job.

483. Upon learning of the sexual abuse of his daughter, her Father, P.O., immediately flew to Utah.

484. While at Utah he discussed the assault with Mazzaglia and Pepper.

485. P.O. recalls both Mazzaglia and Pepper taking extremely defensive positions blaming M.O. for her assault.

486. Mazzaglia showed P.O. the notebook or journal that M.O. had kept detailing her relationship with Moore.

487. Mazzaglia told P.O. that she was going to burn the journal.

488. Despite the fact that Mazzaglia and Pepper had blamed M.O., P.O. expressed his belief that the relationship was inappropriate regardless and that M.O. should not have been put in such a vulnerable position.

489. Pepper and Mazzaglia also confirmed that during group therapy M.O. was held "accountable" for her assault.

490. Upon leaving Vista, P.O. observed that M.O. remained extremely fearful for her own safety.

491. M.O.'s Vista stay cost approximately $140,000 out of pocket.

FIRST CAUSE OF ACTION

Deliberate Indifference Under Title IX—Against Vista at Dimple Dell (Plaintiff M.O.)

492. Plaintiffs incorporate and reallege the allegations of each of the preceding paragraphs as if fully set forth herein.

493. As set forth above, "appropriate persons" under Title IX, including the clinical director of Vista Ryan Pepper, had actual knowledge of sexual harassment, abuse, and the risk of sexual abuse posed by Moore upon M.O.

494. Despite many staff members and Ryan Pepper having actual knowledge, no steps were taken to prevent Moore from sexually harassing and abusing M.O.

495. Not only did Vista and its educational component fail to take any action to protect M.O., it took action *against* M.O. as a result of her confirmation of the abuse.

496. Vista's deliberate response not to take remedial action against Moore until long after it had been aware of the sexual harassment and abuse was clearly unreasonable and constituted deliberate indifference to severe harassment.

497. Vista's deliberate decision not to take remedial action against Moore when it received actual knowledge of the harassment and abuse subjected M.O. to severe, pervasive, and objectively offensive harassment, in the form of sexual assault against M.O.

498. As a result of Vista's failure to respond in a reasonable manner to known harassment, M.O. was deprived of at least some of the educational benefits and opportunities provided by the educational component of Vista.

499. Vista made no effort to assist M.O. in the aftermath of her sexual harassment and assaults, as is its obligation under Title IX. Vista made no attempt to provide resources for her or aid her academically. Instead, Vista retaliated against M.O.

500. M.O. has suffered damages as a result of Vista's deliberate indifference, including but not limited to mental and emotional distress, medical expenses, and lost educational opportunities.

SECOND CAUSE OF ACTION

Retaliation Under Title IX – Against Vista at Dimple Dell (Plaintiff M.O.)

501. Plaintiffs incorporate and reallege the allegations of each of the preceding paragraphs as if fully set forth herein.

502. M.O. engaged in the protected activity of confirming/reporting the suspected sexual abuse when confronted by her therapist about it.

503. Staff members at Vista, including clinical director Ryan Pepper, were aware that M.O. had confirmed the sexual harassment and abuse, and that it constituted a protected activity.

504. Despite this knowledge, Vista took adverse action against M.O.

505. M.O. was subjected to "group therapy sessions" wherein other staff and residents blamed her for the abuse, blamed her for Moore no longer being at Vista, a staff member destroyed important evidence of the abuse (M.O.'s journal), and everyone was instructed not to talk about what had happened between Moore and M.O.

506. Vista's retaliation against M.O. when she was most vulnerable constituted what is known as institutional betrayal—when a trusted and powerful institution acts in a manner that "visit[s] harm upon those dependent on [the institution] for safety and well-being. [4]

507. Institutional betrayals of the kind M.O. experienced due to Vista's actions "exacerbate the impact of traumatic experiences," in a similar manner to betrayal by a trusted person. [5] Rather than aiding students who had experienced the trauma of sexual assault (also aided and abetted and ignored by the program), Vista betrayed M.O.'s trust and magnified her pain.

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[4] Smith, C. P., and Freyd, J.J., *Institutional Betrayal*, 69 Am. Psychol. 6, at 575 (2014), *available at* http://dynamic.uoregon.edu/jjf/articles/sf2014.pdf.

[5] *Id.* at 577.

508. Plaintiff M.O. has suffered damages as a result of Vista's retaliation against her, including but not limited to mental and emotional distress, medical expenses, and lost educational opportunities.

THIRD CAUSE OF ACTION

Negligent Sexual Abuse—Against Toni Mazzaglia, Ryan Pepper, and Jane and John Does 1-50 (Plaintiff M.O.)

509. Plaintiffs incorporate and reallege the allegations of each of the preceding paragraphs as if fully set forth herein.

510. This claim is brought within four years of M.O.'s 18th birthday under Utah Code Ann. § 78B-2-308(3)(b)(i).

511. Defendants Jane and John Does 1-50 (to include Toni Mazzaglia and Ryan Pepper) were made aware of Moore's sexual abuse of M.O. in the fall of 2018 after M.O.'s journal was confiscated. M.O. was under 18 years of age during some portion of Moore's sexual abuse.

512. Defendants Jane and John Does 1-50 (to include Toni Mazzaglia and Ryan Pepper) negligently failed to act to prevent the child sexual abuse from further occurring or to report the sexual abuse to law enforcement.

513. Defendants Jane and John Does 1-50 (to include Toni Mazzaglia and Ryan Pepper) were acting as "legal guardians" over M.O. in this context and were "cohabitating" with M.O., as Vista was a residential treatment program, under U.C.A. §78B-2-308.

514. Plaintiff M.O. has suffered damages as a result of Defendants' negligent permission of sexual abuse, including but not limited to mental and emotional distress, and medical expenses.

FOURTH CAUSE OF ACTION

Medical Malpractice—Against Toni Mazzaglia, Kristin Adams, Ryan Pepper, and Jane and John Does 1-50
(Plaintiffs M.M., B.N., and M.O.)

515. Plaintiffs incorporate and reallege the allegations of each of the preceding paragraphs as if fully set forth herein.

516. Defendants Toni Mazzaglia, Kristin Adams, Ryan Pepper, and Jane and John Does 1-50 (Vista licensed medical professionals and therapists) owed a duty to all Plaintiffs to provide them the same standard of care a reasonable and prudent mental and medical healthcare provider would under similar circumstances.

517. Defendants breached that duty when:

a. Plaintiffs were denied food and medical care;

b. Plaintiffs were subjected to deeply psychologically harmful tactics such as manipulation, degradation, shaming, and isolation;

c. Defendants provided Plaintiffs' private patient information to third parties, including other residents, in violation of Plaintiffs' privacy rights and protections afforded under the Health Insurance Portability and Accountability Act; and

d. Other failures that discovery may uncover.

518. As a direct and proximate result of Defendants' breach of standard of care, Plaintiffs have suffered and continue to suffer significant economic and non-economic injuries, including but not limited to:

a. Past, present, and future medical and mental healthcare expenses;

b. Lost wages and lost wage-earning capacities;

c. Loss of enjoyment of life;

d. Substantial physical, mental, and emotional pain and suffering; and

e. Out of pocket costs.

FIFTH CAUSE OF ACTION

Negligent Employment – Against all Vista Entities (Plaintiffs M.M., B.N., and M.O.)

519. Plaintiffs incorporate and reallege the allegations of each of the preceding paragraphs as if fully set forth herein.

520. Defendant Vista hired negligent and abusive staff members, including but not limited to Moore and other therapists.

521. After hiring Moore and others, Vista did not supervise Moore and others to the extent that they were able to abuse residents at Vista, sexually and otherwise.

522. Vista knew or should have known that employing Moore and others with no supervision posed a foreseeable risk of harm to residents, including a foreseeable risk of sexual assault.

523. Moore inflicted such harm on Plaintiff M.O. when he sexually assaulted her.

524. All other Plaintiffs were harmed by negligent and abusive staff members hired by Vista.

525. Vista's negligent hiring, supervision, and retention of Moore and others manifested a knowing and reckless indifference toward, and a disregard of, the rights of others, including Plaintiffs.

526. Vista's negligent hiring, supervision, and retention of Moore and others proximately caused Plaintiffs to suffer harm, including physical and emotional injury, post-traumatic stress, pain and suffering, and past and future expenses for medical care, counseling, and therapy.

SIXTH CAUSE OF ACTION

Vicarious Liability—Against All Vista Entities
(Plaintiffs M.M., B.N., and M.O.)

527. Plaintiffs hereby incorporate the preceding paragraphs as if fully set forth herein.

528. At all relevant times, Toni Mazzaglia, Kristin Adams, Ryan Pepper, and Jane and John Does 1-50 were agents and employee of the Vista entities.

529. Defendants performed the wrongful acts during the course and scope of their agency and employment.

530. Defendants' actions were motivated, at least in part, by the purpose of serving the Vista entities.

531. Vista is vicariously liable for the other Defendants' wrongful acts.

532. As an additional result of the acts and omissions set forth generally above, and other acts and omissions of a similar nature, Plaintiffs have suffered past and future damages for costs of medical treatment and healthcare for Plaintiffs due to said injuries, past and future lost wages, past and future general damages for pain and suffering, past and future damages for emotional distress, and other past and future general and special damages as well as other damages known and unknown to Plaintiffs at this time.

SEVENTH CAUSE OF ACTION

Intentional Infliction of Emotional Distress—Against All Defendants
(Plaintiffs M.M., B.N., and M.O.)

533. Plaintiffs incorporates all paragraphs of this Complaint as if fully set forth herein.

534. Defendants acted intentionally when they repeatedly subjected Plaintiffs and others to repeated abusive tactics under the guise of therapeutic practices.

535. Defendants' conduct toward Plaintiffs as alleged herein was extreme and outrageous.

536. Plaintiffs suffered and will continue to suffer severe emotional distress.

537. Defendants' extreme and outrageous conduct caused the severe emotional distress that Plaintiffs have suffered.

538. As a consequent, proximate, and foreseeable result of Defendants' wrongful conduct, Plaintiffs have suffered, and continue to suffer, great pain of mind and body, shock, emotional distress, physical manifestations of emotional distress, embarrassment, anxiety, and loss of enjoyment of life. Plaintiffs have sustained and will continue to sustain loss of earnings and earning capacity and have incurred and will continue to incur expenses for medical and psychological treatment, therapy, and counseling.

EIGTH CAUSE OF ACTION

Negligent Infliction of Emotional Distress—Against All Defendants (Plaintiffs M.M., B.N., and M.O.)

539. Plaintiffs incorporate all paragraphs of this Complaint as if fully set forth herein.

540. Defendants directed a campaign of harassment, shame, and emotional abuse towards Plaintiffs in a manner that is unthinkable for any organization responsible for their care.

541. Defendants were negligent in their actions, courses of conduct, and omissions as described herein.

542. Defendants knew or should have known that emotional distress, with physical manifestations, was the likely foreseeable result of their actions, courses of conduct, and omission as described above.

543. Defendants' actions and courses of conduct were the direct and proximate cause of Plaintiffs' severe emotional distress with physical manifestations.

544. The emotional distress sustained by Plaintiffs was of such a nature that a reasonable minor child would have suffered similar emotional distress, with physical manifestations, as the result of conduct by such reasonable care facilities.

545. As a consequent, proximate, and foreseeable result of Defendants' wrongful conduct, Plaintiffs have suffered, and continue to suffer, great pain of mind and body, shock, emotional distress, physical manifestations of emotional distress, embarrassment, anxiety, and loss of enjoyment of life. Plaintiffs have sustained and will continue to sustain loss of earnings and earning capacity and has incurred and will continue to incur expenses for medical and psychological treatment, therapy, and counseling.

NINTH CAUSE OF ACTION

Gross Negligence – Against All Defendants (Plaintiffs M.M., B.N., and M.O.)

546. Plaintiffs incorporate and reallege the allegations of each of the preceding paragraphs as if fully set forth herein.

547. Vista and other Defendants undertook to ensure the security and safety of all Plaintiffs while in Vista's care.

548. Vista and other Defendants therefore had a duty to protect Plaintiffs from foreseeable injury.

549. Vista and other Defendants became aware of the danger posed by Moore and other staff.

550. Upon becoming aware of the danger posed by Moore and other staff, it was foreseeable that M.O. or others could be sexually assaulted or harassed in the same manner. Additionally, Plaintiffs and others could continue to be harmed by other negligent staff.

551. Vista and other Defendants took no reasonable steps to respond to M.O.'s report, or any other reports of harm at the hands of Vista staff.

552. Vista and other Defendants grossly deviated from the standard practice in abiding by national standards of ethics and practices in the care and treatment of minors, including Plaintiffs.

553. Vista and other Defendants' total failure to respond appropriately to reports of sexual assault and other abuse or to take any steps to prevent future sexual assaults or other abuse demonstrated a failure to observe even slight care and manifested knowing and reckless indifference to the rights of Vista residents, including Plaintiffs.

554. Vista and other Defendants' failure to act reasonably to warn or prevent harm to Plaintiffs as a result of Moore's and others' actions proximately caused Plaintiffs to suffer harm, including physical and emotional injury, post-traumatic stress, pain and suffering, and past and future expenses for medical care, counseling, and therapy.

TENTH CAUSE OF ACTION

Fraud/Intentional Misrepresentation – Vista Entities
(Plaintiffs M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F., M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E.)

555. Plaintiffs incorporate and reallege the allegations of each of the preceding paragraphs as if fully set forth herein.

556. Vista and the Referring therapists and/or educational consultants entered into and engaged in a referral scheme wherein referring therapists and/or consultants would recommend and steer patients to Vista treatment centers for additional treatment.

557. Part of the scheme required the referring therapists and/or consultants to make representations to Plaintiffs M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F.,

M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E. and their parents and/or caregivers regarding the necessity for further treatment at Vista.

558. The additional treatment was not necessary.

559. Representations regarding the need for further treatment were made without disclosing the referral scheme between Vista and the referring therapists.

560. The Referring therapists and Vista recommended additional treatment knowing that such treatment was not necessary.

561. Vista encouraged the referring therapists and/or consultants through a financial scheme to make unnecessary recommendations.

562. The financial scheme between Vista and the referring therapists and/or consultants was not disclosed to Plaintiffs and their parents and/or caregivers.

563. Vista and the referring therapists actively concealed the referral scheme from Plaintiffs M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F., M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E. and their parents and/or caregivers.

564. Plaintiffs and their parents and/or caregivers relied on the false recommendations for additional treatment made by the Referring therapists.

565. The referral scheme between Vista and the referring therapists and/or consultants was an important or material fact which, had it been known to the relevant Plaintiffs and their parents and/or caregivers, would have precluded Plaintiffs from engaging in any treatment at Vista.

566. Failure to disclose the financial scheme between Vista and the referring therapists and/or consultants constitutes an affirmative misrepresentation as the referring therapists/consultants and Vista had an obligation and duty to disclose the whole truth with respect to why referring therapists and/or consultants recommended further treatment at Vista.

567. Vista and the referring therapists and/or consultants intended for the relevant Plaintiffs and their parents and/or caregivers to rely on their recommendation for further treatment at Vista.

568. The relevant Plaintiffs and their parents and/or caregivers reasonably relied on the recommendations of Vista and the referring therapists and/or consultants for further treatment at Vista.

569. Based on this reliance and the fraud perpetrated by Vista and the referring therapists and/or consultants, the relevant Plaintiffs and their parents and/or caregivers have suffered compensatory damages relating to the costs of care while at Vista, physical and emotional injury, post-traumatic stress, pain and suffering, and past and future expenses for medical care, counseling, and therapy.

ELEVENTH CAUSE OF ACTION

Negligent Misrepresentation – Vista Entities
(Plaintiffs M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F., M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E.)

570. Plaintiffs incorporate and reallege the allegations of each of the preceding paragraphs as if fully set forth herein.

571. Vista and the referring therapists and/or consultants entered into and engaged in a referral scheme wherein referring therapists and/or consultants would recommend and steer patients under their care to Vista treatment centers for additional treatment.

572. Part of the scheme required the referring therapists and/or consultants to make representations to Plaintiffs M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F., M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E. and their parents and/or caregivers regarding the necessity for further treatment at Vista.

573. The additional treatment was not necessary.

574. Representations regarding the need for further treatment were made without disclosing the referral scheme between Vista and the referring therapists and/or consultants.

575. The referring therapists and/or consultants and Vista recommended additional treatment failing to consider whether further treatment was actually necessary.

576. Vista encouraged the referring therapists and/or consultants through a financial scheme to make unnecessary recommendations.

577. The financial scheme between Vista and the referring therapists and/or consultants was not disclosed to Plaintiffs M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F., M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E. and their parents and/or caregivers.

578. Vista and the referring therapists and/or consultants actively concealed the referral scheme from the relevant Plaintiffs and their parents and/or caregivers.

579. Had the relevant Plaintiffs and their parents and/or caregivers been aware of the financial scheme between Vista and the Defendant Caregivers they would not have elected to engage in further care at Vista.

580. Vista and the referring therapists and/or consultants were in the best position to notify the relevant Plaintiffs and their parents and/or caregivers of the financial scheme between Vista and the referring therapists and/or consultants and how such a scheme may inform recommendations for further care.

581. Vista and the referring therapists and/or consultants had a financial incentive to engage the relevant Plaintiffs and their parents and/or caregivers in transactions for further care at Vista.

582. It was reasonable for the relevant Plaintiffs and their parents and/or caregivers to rely on the recommendations for further care made by Vista and the referring therapists and/or consultants.

583. Based on this reliance and the fraud perpetrated by Vista and the referring therapists and/or consultants, Plaintiffs M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F., M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E. and their parents and/or caregivers have suffered compensatory damages relating to the costs of care while at Vista, physical and emotional injury, post-traumatic stress, pain and suffering, and past and future expenses for medical care, counseling, and therapy.

PRAYER FOR RELIEF

Wherefore, Plaintiffs pray for judgment against Defendants as follows:

1. For judgment in Plaintiff M.O.'s favor and against Defendants for Title IX violations for deliberate indifference and retaliation;

2. For judgment in Plaintiff M.O.'s favor and against Defendants for negligent sexual abuse;

3. For judgment in Plaintiffs M.M., B.N., and M.O.'s favor and against Defendants for medical malpractice;

4. For judgment in Plaintiffs M.M., B.N., and M.O.'s favor and against Defendants for negligent employment;

5. For judgment in Plaintiffs M.M., B.N., and M.O.'s favor and against Defendants for vicarious liability;

6. For judgment in Plaintiffs M.M., B.N., and M.O.'s favor and against Defendants for intentional infliction of emotional distress;

7. For judgment in Plaintiffs M.M., B.N., and M.O.'s favor and against Defendants for negligent infliction of emotional distress;

8. For judgement in Plaintiffs M.M., B.N., and M.O.'s favor and against Defendants for gross negligence;

9. For a judgement in Plaintiffs M.M., B.N., R.P., A.A., P.D., M.L., A.B., M.K., E.S., A.J., C.F., M.E.M., J.H., D.H., B.M., E.P., E.E., E.A., K.E., K.G., K.S., N.W., R.G., R.B., S.E.'s favor against Defendants for fraud and negligent misrepresentation;

10. For an award of compensatory damages in favor of Plaintiffs and against all Defendants in an amount to be determined at trial;

11. For an award of economic damages in favor of Plaintiffs and against all Defendants in an amount to be determined at trial;

12. For an award of general damages in favor of Plaintiffs and against all Defendants in an amount to be determined at trial;

13. For an award of reasonable attorneys' fees and costs associated with this action;

14. For an award of post-judgment interest as allowed by law;

15. For such other and further relief as the Court may deem just.

JURY DEMAND

Plaintiffs demand a trial by jury on all causes of action.

DATED this 23rd day of March, 2022.

PARSONS BEHLE & LATIMER

/s/ Michael W. Young

Michael W. Young
Lauren M. Hunt

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on March 23, 2022, a true and correct copy of the foregoing document was served on all counsel of record by electronically filing it with the Clerk of the Court.

/s/ Michael W. Young