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IN THE THIRD DISTRICT COURT
IN AND FOR SALT LAKE COUNTY, STATE OF UTAH

STATE OF UTAH, Plaintiff, vs. **JORGE GUSTAVO GONZALEZ, SR.** DOB: 12/25/1968 Defendant IGNACIO N. GONZALEZ-VILLARRUEL DOB: 07/05/1999 Codefendant	Custody status: out of custody **INFORMATION** Utah Attorney General Case No. 2022-38 Case no. Judge: Codefendant case no.

THE STATE OF UTAH TO THE ABOVE-NAMED DEFENDANT:

The undersigned, Special Agent Lane Olson, Office of the Utah Attorney General, Medicaid Fraud and Patient Abuse Division, upon a written declaration states on information and belief that the defendant committed the following crimes:

COUNT 1: INTENTIONAL FINANCIAL EXPLOITATION OF A VULNERABLE ADULT, Utah Code § 76-5-111.4(2), a second-degree felony, as follows: That on or about January 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., acting intentionally or knowingly, unjustly or improperly used or

managed the resources of a vulnerable adult for the profit or advantage of someone other than the vulnerable adult; the aggregate value of the resources used was or exceeded $5,000.00.

To wit: Between January 1, 2021, through January 31, 2022, used his position as landlord or manager of a resident-support facility, and as Social Security representative payee of M.B.D., a vulnerable adult, to acquire payments for rent, while failing to provide necessary services or a safe, clean residential environment. The acquired rent totaled over $13,000.00.

COUNT 2: INTENTIONAL FINANCIAL EXPLOITATION OF A VULNERABLE ADULT, Utah Code § 76-5-111.4(2), a second-degree felony, as follows: That on or about January 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., acting intentionally or knowingly, unjustly or improperly used or managed the resources of a vulnerable adult for the profit or advantage of someone other than the vulnerable adult; the aggregate value of the resources used was or exceeded $5,000.00.

To wit: Between January 1, 2021, through January 31, 2022, the defendant used his position as landlord or manager of a resident-support facility to acquire payments for rent for K.R.S., a vulnerable adult, while failing to use or manage those payments to provide necessary services or a safe, clean residential environment. The acquired rent totaled at least $13,000.00.

COUNT 3: INTENTIONAL FINANCIAL EXPLOITATION OF A VULNERABLE ADULT, Utah Code § 76-5-111.4(2), a third-degree felony, as follows: That on or about January 1–31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., acting intentionally or knowingly, unjustly or improperly used or managed the resources of a vulnerable adult for the profit or advantage of someone other than the vulnerable adult; the aggregate value of the resources used was less than $5,000 or cannot be determined.

To wit: Between January 1–31, 2022, the defendant used his position as landlord or manager of a resident-support facility to acquire payment for rent for D.G.R., a vulnerable adult, then failed to use or manage said payment to provide necessary services or a safe, clean residential environment. The acquired rent was $1,400.00.

COUNT 4: INTENTIONAL FINANCIAL EXPLOITATION OF A VULNERABLE ADULT, Utah Code § 76-5-111.4(2), a third-degree felony, as follows: That on or about January 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., acting intentionally or knowingly, unjustly or improperly used or managed the resources of a vulnerable adult for the profit or advantage of someone other than the vulnerable adult; the aggregate value of the resources used was less than $5,000 or cannot be determined.

To wit: Between January 1, 2021, through January 31, 2022, the defendant used his position as landlord or manager of a resident-support facility to acquire payments for rent for M.K.J., a vulnerable adult, while failing to use or manage those payments to provide necessary services or a safe, clean residential environment. The total acquired rent is unknown at this time.

COUNT 5: INTENTIONAL FINANCIAL EXPLOITATION OF A VULNERABLE ADULT, Utah Code § 76-5-111.4(2), a third-degree felony, as follows: That on or about January 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., acting intentionally or knowingly, unjustly or improperly used or managed the resources of a vulnerable adult for the profit or advantage of someone other than the vulnerable adult; the aggregate value of the resources used was less than $5,000 or cannot be determined.

To wit: Between February 1, 2021, through January 31, 2022, the defendant used his position as landlord or manager of a resident-support facility to acquire payments for rent for C.X.N., a vulnerable adult, while failing to use or manage those payments to provide necessary services or a safe, clean residential environment. The total acquired rent is unknown at this time.

COUNT 6: INTENTIONAL ABUSE OR NEGLECT OF A VULNERABLE ADULT, Utah Code § 76-5-111(2), a class A misdemeanor, as follows: That on or about January 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., having the care or custody of a vulnerable adult, intentionally or knowingly caused or permitted that vulnerable adult's person or health to be neglected.

To wit: Between January 1, 2021, through January 31, 2022, as a landlord or manager of a residential-support facility, the defendant allowed M.B.D., a vulnerable adult, to live in unsanitary, unsafe conditions, without sufficient staffing or resources.

COUNT 7: INTENTIONAL ABUSE OR NEGLECT OF A VULNERABLE ADULT, Utah Code § 76-5-111(2), a class A misdemeanor, as follows: That on or about January 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., having the care or custody of a vulnerable adult, intentionally or knowingly caused or permitted that vulnerable adult's person or health to be neglected.

To wit: Between January 1, 2021, through January 31, 2022, as a landlord or manager of a residential-support facility, the defendant allowed K.R.S., a vulnerable adult, to live in unsanitary, unsafe conditions, without sufficient staffing or resources.

COUNT 8: INTENTIONAL ABUSE OR NEGLECT OF A VULNERABLE ADULT, Utah Code § 76-5-111(2), a class A misdemeanor, as follows: That on or about January 1–31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., having the care or custody of a vulnerable adult, intentionally or knowingly caused or permitted that vulnerable adult's person or health to be neglected.

To wit: Between January 1–31, 2022, as a landlord or manager of a residential-support facility, the defendant allowed D.G.R., a vulnerable adult, to live in unsanitary, unsafe conditions, without sufficient staffing or resources.

COUNT 9: INTENTIONAL ABUSE OR NEGLECT OF A VULNERABLE ADULT, Utah Code § 76-5-111(2), a class A misdemeanor, as follows: That on or about January 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE

GUSTAVO GONZALEZ, SR., having the care or custody of a vulnerable adult, intentionally or knowingly caused or permitted that vulnerable adult's person or health to be neglected.

To wit: Between January 1, 2021, through January 31, 2022, as a landlord or manager of a residential-support facility, the defendant allowed M.K.J., a vulnerable adult, to live in unsanitary, unsafe conditions, without sufficient staffing or resources.

COUNT 10: INTENTIONAL ABUSE OR NEGLECT OF A VULNERABLE ADULT, Utah Code § 76-5-111(2), a class A misdemeanor, as follows: That on or about February 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., having the care or custody of a vulnerable adult, intentionally or knowingly caused or permitted that vulnerable adult's person or health to be neglected.

To wit: Between February 1, 2021, through January 31, 2022, as a landlord or manager of a residential-support facility, the defendant allowed C.X.N., a vulnerable adult, to live in unsanitary, unsafe conditions, without sufficient staffing or resources.

COUNT 11: LICENSING VIOLATION ENDANGERING PERSONS IN HUMAN SERVICES PROGRAM, Utah Code § 26B-2-113(1)(a), a class A misdemeanor, as follows: That on or about January 1, 2021, through January 31, 2022, in Salt Lake County, State of Utah, the defendant, JORGE GUSTAVO GONZALEZ, SR., owned, conducted, maintained, managed, or operated a human services program in violation of Title 26B, Chapter 2, Part 1 of the Utah Code, and the violation endangered or harmed the health, welfare, or safety of persons participating in that program.

To wit: Between January 1, 2021, through January 31, 2022, the defendant was an owner and manager of a residential-support facility in violation of the licensing requirements for Human Services programs and facilities, which violation led to the residents being subjected to unsanitary and unsafe conditions.

THIS INFORMATION IS BASED ON EVIDENCE OBTAINED FROM THE FOLLOWING WITNESSES: Special Agent L. Olson, Detective M. Utley, Detective K. Borders, Sgt. J. Sampson, G. Bourke, Area Fire Marshal D. Bradley, N. Heaton, A. Gerritsen Hickok, S. Reed, B. Bleak

DECLARATION OF PROBABLE CAUSE:

As an investigator with the Utah Attorney General's Office, Medicaid Fraud and Patient Abuse Division, I, Special Agent Lane Olson, have investigated allegations regarding the defendants, Jorge Gustavo Gonzalez, Sr. ("Gustavo"), and Ignacio N. Gonzalez-Villarruel ("Ignacio"). (The defendants' given names are used herein for clarity.) My investigation has provided evidence that the defendants committed the offenses of Financial Exploitation of a Vulnerable Adult involving multiple victims, Abuse of a Vulnerable Adult involving neglect of the same victims, and a Licensing Violation.

From July of 2017 through January of 2022, Evergreen Place, LLC ("Evergreen"), a board-and-care facility at 163 E. 7800 South, Midvale, Salt Lake County, Utah, was owned and operated by the defendants. Defendant Gustavo originally purchased Evergreen. A Certificate of Incorporation dated 7/13/2017 listed Gustavo and his then-18-year-old son, Ignacio, as managers. The Policy and Procedure Manual adopted by Evergreen and "[r]evised 08/17/2017," included under its Mission statement the principles of "[p]roviding personal and social care in a safe, clean, residential environment" and "[t]wenty-four hour, seven-day-a-week general monitoring of residents, and reporting on noticed changes in physical, mental or emotional status."

Gustavo nominally conveyed ownership to Ignacio in 2019, but effectively remained in joint control of the facility with his son. An application for licensure as a "Residential Support" facility (a Human Services program falling under Title 26B, Chapter 2, Part 1 of the Utah Code) was filled out by Ignacio on 5/02/2021, but a license was never approved or issued. In October of 2021, a letter from the Office of Licensing was sent to Gustavo expressly informing him that licensure had been denied.

As of early January, 2022, seventeen adult men were living at Evergreen. Most, if not all, of these men were vulnerable adults, as defined at Utah Code § 76-5-111(1)(a)(xiv), based on various forms and levels of mental impairment. The vulnerable-adult residents who suffered individually identifiable inequities, in addition to the general neglect endured by all the residents, included the following men (designated here by their initials to protect their privacy): MBD, KRS, DGR, MKJ, and CXN.

Events in January of 2022 brought Evergreen to the attention of the Unified Police Department ("UPD"), Adult Protective Services ("APS"), and other agencies. The resulting investigations established that the facility's furnace had failed by 1/04/2022. Although at least two space heaters were provided, one resident complained that he "nearly froze to death" due to the cold. Then, on or before 1/09/2022, raw sewage flooded in the basement and later backed up in upstairs living quarters. At one point, a resident was observed walking through sewage water in his bare feet. In this period, the defendants made no known efforts to find alternate housing for the residents, or to notify their families or caseworkers.

The heating and sewage conditions still had not been fully resolved by 1/25/2022. On that date, Area Fire Marshal D. Bradley, Unified Fire Authority, inspected the premises. In his Fire Inspection Report of 1/26/2022, Marshal Bradley noted nine safety-related code violations: Fire Alarm System Not Inspected or Operational; No Appropriate Fire Extinguishers on Premises; No Smoke Alarms Active; Portable Heaters Connected to Extension Cords; Emergency Exits Blocked or Locked; Emergency Exit Signs Not Properly Maintained; No Workable Secondary Emergency Exit from Basement; Missing Sheetrock Around Basement Walls and Understairs; and, Hot Water Appliance Not Having Appropriate Cover Over Pilot Light.

In response to the overall conditions at Evergreen, the facility was shut down on 1/26/2022. The residents had to go through a decontamination process that included removing all their clothing and donning disposable hazmat suits over donated clothes. Resident MBD was covered in bedbugs and experiencing shortness of breath as well as other medical issues; he was transported to an emergency room for treatment and evaluation. New places to stay—in other facilities or with family—were arranged for the residents by family members, Valley Behavioral Health ("VBH") personnel, and State officials.

Neither the heating and sewage issues of January 2022 nor the code violations were the only neglectful circumstances endured by the Evergreen residents. According to the various observers interviewed and documents reviewed by your declarant, the defendants had permitted unsafe and neglectful circumstances to continue for at least the better part of a year, despite collecting from $1000 to $1400 per month from each resident. (Resident MBD had told APS Clinical Investigator A. Gerritsen Hickok in April of 2021 that he lived in a "flop house.")

These circumstances included the following:

- Unsanitary, squalid conditions. An overall lack of sanitation and hygiene was the general rule, especially in living quarters, including visibly grimy floors, filthy carpeting, dirty walls and other surfaces, overflowing trash, and stained and sunken mattresses and pillows. VBH "Team Lead" B. Bleak noted that the level of "dirtiness" in the facility had become "progressively worse over about six months" preceding the closure. Bleak also stated that "a lot of the time when we would get there . . . the immediate space that you'd walk into often smelled like urine or feces."

  DGR's mental impairment led to extreme issues with hygiene that went unchecked given the lack of care. For days if not weeks in January 2022 his room and bathroom were smeared with feces, as was his person.

  Bedroom window coverings, if any, generally consisted of broken blinds, or towels and sheets strung up as makeshift curtains. DGR's bedroom had no light bulb.

- Insect infestations. Staff member N. Heaton said that the facility had had an issue with bedbugs for about a year prior to March 2022, when she was interviewed. This is corroborated by the fact that resident MBD had been taken previously to the emergency room on 4/19/2021, covered in lice and bedbugs. Despite that earlier infestation, Ignacio had denied to Gerritsen Hickok of APS that there was any bedbug problem.

  B. Bleak of VBH stated that she was also aware of resident CXN having had bedbug issues and another resident having had body lice. Other residents were treated for the same. Bleak noted that "toward the end" of the facility's open status, the insect

infestation was so extensive that the carpeting itself seemed to shift from the bugs moving. Bleak stated further that, apparently due to the standing sewage water toward the end of January 2022, "there were bugs climbing walls and on beds."

- Crowded conditions. As of the January 2022 investigations, the facility had only one functional shower for seventeen adult men.

- Accessible "sharps." Sharp objects like kitchen knives, or "sharps," were frequently left accessible to residents. Given that some residents, including CXN, suffered from suicidal ideation, this was an ongoing hazard. The subject was discussed "a lot" with Gustavo, according to B. Bleak.

- Staff issues. According to B. Bleak, sometimes VBH personnel would arrive at Evergreen during regular work hours and find no staff on duty at all. No staff were on duty after 5:00 p.m. Staff member N. Heaton said that she had not received any training in the year she had been working at Evergreen. Heaton said only one employee worked at a time, and the hours were 9:00 a.m. to 5:00 p.m. (Part of the year, according to Heaton, her hours had been 9–1 and 5–8, but then they were switched back to 9–5.) Heaton worked only half time at the Midvale Evergreen facility; two men—"Javier" and "Santos"—worked the other half of the week and weekends, respectively. The sole employee on site was responsible for cooking and preparing all meals, distributing medications and maintaining a log of the same, doing all housekeeping and cleaning up, and assisting with "daily living" needs of the seventeen residents.

  The inadequate staffing led to ongoing issues. In addition to the sanitation and care issues, conflicts between residents were frequent, with calls for police assistance occurring every couple of days according to N. Heaton. The most basic of residents' daily-living needs were not addressed. As early as March 2021, a housing-assistance caseworker memorialized concerns about CXN not having his needs met at Evergreen. For example, because no Evergreen staff was helping CXN despite being notified of the need, he had gone weeks without having his clothes washed.

- Food and meal issues. Because food was kept locked up and no staff was onsite after hours, access to food was limited. Because staff left at 5:00 p.m. most days, the residents' dinner would be very early.

- Medical issues. No nurse or other trained, currently licensed personnel were on staff. Due to the lack of any other available personnel, medications would be left with any staff member who was available. According to B. Bleak, when no staff member was on premises, VBH personnel would have to take medications back to their own nurse to be secured. In any event, residents did not always receive their medications from Evergreen

staff. On one occasion, a staff member handed a bag filled with CXN's medications back to a VBH worker, and could offer no explanation as to why there were so many leftover medications.

Residents DGR, CXN, and at least one other resident were diabetic. Gustavo told S. Reed that diabetic meals would be provided to DGR, but according to staff member Heaton, no diabetic meals were ever prepared. As memorialized by Gerritsen Hickok, DGR had told family that Evergreen staff were "feeding him cheap sugary cereal each day for breakfast and feeding him things like corn dogs, Oreo cookies, ice cream sandwiches and high carb meals that are not acceptable as [DGR] is severely diabetic." Also, although insulin is supposed to be refrigerated, DGR's insulin was observed sitting on a windowsill.

In April 2021, VBH personnel talked to Ignacio about their concerns that resident MKJ was not receiving his medications; they noted the same concern in June and July of that year. In September 2021, VBH personnel noted in their records that resident KRS needed a different placement that could "provide sufficient medication monitoring and distribution due to staff error or inadequate medication storage at Evergreen Place."

When law enforcement and APS first visited Evergreen in January 2022, they were shown a logbook for medications. Focusing on DGR at that time, it was observed that the logbook was not filled out properly and that medications had not been given to DGR in a timely fashion. When a search warrant was executed days later, the logbook was missing.

According to B. Bleak, concerns raised by VBH personnel to Gustavo brought only excuses and the repeated claim that they were "working on it." Other staff members would simply walk away, unwilling to try to communicate. When S. Reed complained to Gustavo by phone about the issues discovered shortly after DGR's arrival at the facility, he hung up on her.

Resident MBD's Social Security payments of $1,013.00 per month went directly to Ignacio's personal checking account. Ignacio was MBD's representative payee beginning in January 2018, meaning that Ignacio had complete control of MBD's finances. For the period of January 2021 to January 2022, therefore, MBD paid $13,169.00 in rent. DGR's sibling paid $1,400.00 as rent for January 2022, but DGR was only there for a few weeks before the facility was shut down. Resident KRS's rent was also $1,000.00 per month; because he had lived at Evergreen since some time in 2020, he had paid $13,000.00 over the referenced period. The rents charged for residents MKJ and CXN are not known at this time.

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Pursuant to Utah Code Annotated § 78B-18a-106, I declare under criminal penalty under the law of Utah that the foregoing is true and correct.

Signed on the 21st day of June, 2023,

/s/ Lane Olson
LANE OLSON, Special Agent
Declarant

Authorized for presentment and filing:
SEAN D. REYES, Utah Attorney General

/s/ Langdon Fisher
LANGDON FISHER
Assistant Utah Attorney General
DATED: June 21, 2023
AG Case No. 2022-38