OIDO
Office of the Immigration Detention Ombudsman

OIDO INSPECTION

Cibola County Correctional Center

OIDO-23-013
October 13, 2023

OIDO is an independent office within the Department of Homeland Security.

Department of Homeland Security
Washington, DC 20528

OIDO
Office of the Immigration Detention Ombudsman

October 13, 2023

MEMORANDUM FOR: Patrick J. Lechleitner
Deputy Director and Senior Official
Performing the Duties of the Director
U.S. Immigration and Customs Enforcement

FROM: David D. Gersten
Acting Ombudsman
Office of the Immigration Detention Ombudsman

DAVID D GERSTEN
Digitally signed by DAVID D GERSTEN
Date: 2023.10 20 13:06:42 -04'00'

SUBJECT: OIDO-23-013
Cibola County Correctional Center
August 9-11, 2022

Attached is the Office of the Immigration Detention Ombudsman's (OIDO) final report based on its inspection of Cibola County Correctional Center (CCCC) in Milan, New Mexico on August 9-11, 2022. We reviewed the facility's performance as well as compliance with the 2011 Performance-Based National Detention Standards (hereinafter referred to as the 2011 PBNDS) and contract terms.

The report contains nine recommendations aimed at improving operations and conditions at CCCC and its compliance with the 2011 PBNDS and contract terms. Your office concurred with all nine recommendations. Based on the information provided in your responses to the draft report, we consider all recommendations addressed and closed.

Attachments

OIDO
Office of the Immigration Detention Ombudsman

OIDO INSPECTION
OF
CIBOLA COUNTY CORRECTIONAL CENTER
Milan, New Mexico

Executive Summary

In August 2022, the Office of the Immigration Detention Ombudsman (OIDO) conducted an unannounced inspection of the Cibola County Correctional Center (CCCC) in Milan, New Mexico to assess its compliance with U.S. Immigration and Customs Enforcement (ICE) detention standards and contract terms. During its inspection, OIDO reviewed areas identified during previous inspections of the facility as well as several additional areas of review. Specifically, the areas of review included environmental health and safety, admission and release, custody classification system, security and control, population counts, Special Management Units, staff-detainee communication, medical care, and telephone access.

OIDO's inspection led to several findings. CCCC complied with standards in four areas, had violations in 16 areas, and had three areas of concern. The facility's 16 violations were in the following areas: cleanliness and sanitation of housing unit, blockage of drainage pipe, inspection of fire extinguisher, documentation of admission and release, monitoring detainee movement, documentation of ICE ERO visits and detainee communications, medical staffing, credentialing, annual training, annual peer review, documentation of quarterly meetings and internal reviews, securing medical information and medications, evaluation and distribution of medications, and providing required contact information. While OIDO found 16 violations, it notes that the facility made timely corrective actions to address deficiencies in two areas. Finally, the three areas of concern included management and labeling of hazardous chemicals, identification of vulnerable populations, and completion of segregation records.

OIDO made nine recommendations designed to improve operations at the facility and meet ICE detention standards and contract terms.

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Introduction

Pursuant to its statutory responsibilities, the Department of Homeland Security (DHS) Office of the Immigration Detention Ombudsman (OIDO) Detention Oversight (DO) Division conducts independent, objective, and credible inspections of Immigration and Customs Enforcement (ICE) facilities throughout the United States. During its inspections, OIDO often completes follow-up assessments to determine whether a facility has taken corrective action to resolve violations or concerns identified during a prior inspection. OIDO also reviews, examines, and makes recommendations to address concerns with or violations of contract terms regarding immigration detention facilities and services.

In August 2022, OIDO conducted an unannounced inspection of the Cibola County Correctional Center (CCCC) to review the facility's performance and determine whether it followed the applicable standards, the 2011 Performance-Based National Detention Standards (hereinafter referred to as the 2011 PBNDS) and contract terms.[1] OIDO found four areas of compliance, two resolved areas of initial non-compliance, 14 areas of noncompliance, and three areas of concern.

Background

ICE Enforcement and Removal Operations (ERO) oversees the detention of noncitizens at facilities throughout the United States, which it manages directly or in conjunction with private contractors or federal, state, or local governments. ICE uses several detention standards to regulate conditions of confinement, program operations, and management expectations within the agency's detention system.[2] In addition, ICE uses the COVID-19 Pandemic Response Requirements (PRR) to assist detention facility operators in sustaining operations while mitigating risk to the safety and wellbeing of detainees due to COVID-19.[3]

CCCC is a contract detention facility located in Milan, New Mexico. CoreCivic operates the facility under a contract with ICE. The facility has capacity for 1,116 detainees and houses adult male detainees for ICE as well as male and female detainees for the U.S. Marshals Service and Cibola County. ICE detainees are not allowed to interact with non-ICE detainees; ICE detainees are housed separately in Unit 100. The facility had an average daily population of 74 ICE detainees in fiscal year 2022.[4] At the time of OIDO's inspection, the facility held a total of 895 detainees; 57 were ICE detainees.

Objective, Scope, and Methodology

The OIDO team performed an unannounced inspection of CCCC. Specifically, OIDO inspectors reviewed the following areas: environmental health and safety; admission and release; custody classification, security and control; population counts; Special Management Units (SMUs); staff-

[1] At the time of inspection, OIDO had one case manager making routine visits to the facility.
[2] ICE currently has four detention standards in use at adult detention facilities throughout the United States. These include: 2000 National Detention Standards, 2008 Performance-Based National Detention Standards, 2011 Performance-Based National Detention Standards, and 2019 National Detention Standards.
[3] https://www.ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities.pdf.
[4] See ICE FY 2022 Detention Statistics.

detainee communication; medical care; and telephone access. OIDO's objective was to assess the facility's performance and its compliance with the 2011 PBNDS and its contract terms. These specific areas were chosen based on the findings of previous inspections done by the Nakamoto Group on May 3-5, 2022, and ICE Office of Professional Responsibility (OPR) Office of Detention Oversight (ODO) on June 21-24, 2021, and November 29-December 2, 2021.

A team of seven personnel executed the inspection. The inspection team conducted interviews with ICE ERO employees, facility staff, and detainees, made direct observations of facility conditions and operations, and reviewed documentary evidence, including but not limited to, facility policies and procedures, reports and records, logbooks, and video surveillance.

Results of Inspection

OIDO's inspection led to several findings. OIDO found that CCCC complied with standards and contract terms in four areas reviewed. The facility had 16 violations in the following areas: cleanliness and sanitation, blockage of drainage pipe, inspection of fire extinguishers, documentation of ICE detainee admission and release, monitoring detainee movement, documentation of ICE ERO visits and ICE ERO/detainee communications, medical staffing, credentialing, annual training, annual peer review, documentation of quarterly meetings and internal reviews, securing medical information and medications, evaluation and distribution of medications, and providing required contact information. In addition, OIDO found three areas of concern, including the management and labeling of hazardous chemicals, identification of vulnerable populations, and completion of segregation records.

While OIDO found 16 violations, it notes that the facility made timely corrective actions to address deficiencies in two areas, including cleaning housing unit conditions and clearing a blocked drainage pipe.

The inspection results are divided into four sections: areas of compliance, resolved areas of initial non-compliance, areas of non-compliance, and areas of concern.

A. Areas of Compliance

The Facility Complied with Standards for Processing Detainee Property During Admission and Release

The 2011 PBNDS section 2.1 on admission and release requires each facility to implement written policies and procedures for the intake and reception of newly arrived detainees. Detainees shall be screened, and their personal property and valuables shall be checked for contraband, inventoried, receipted, and stored. Each facility shall have a procedure for taking inventory and receipt of detainee baggage and personal property. Facility staff will prepare an itemized list of a detainee's property using an inventory form. The same form will be used to check and return detainee personal property upon release.

OIDO interviewed the Admissions and Release Supervisor and reviewed the detention files of nine detainees held at the facility at the time of OIDO's inspection. OIDO did not find any discrepancies in the detainee property paperwork. Moreover, OIDO observed the property room and found that detainee property was properly inventoried and stored. OIDO also reviewed the files of five

detainees who had been released from the facility and did not find any discrepancies in their property information. Finally, during its inspection, OIDO observed as the facility processed two detainees for release and noted that the facility staff followed proper procedures to release the detainees with their personal property and money.

The Facility Complied with Standards for Completing Formal Population Counts

The 2011 PBNDS section 2.8 on population counts requires facilities to conduct formal counts in a predetermined manner at specific times of the day and night. A formal count shall be conducted at least once every eight hours, with a shift supervisor verifying its accuracy. Additional counts, at the discretion of the facility, are encouraged. OIDO reviewed the logbook containing the records for formal counts over the previous 60 days and determined that the facility was properly conducting the required population counts as well as additional counts. The Unit Manager provided a copy of the facility schedule for official counts, which showed that additional counts are a part of the normal schedule for the detainee population.

The Facility Complied with Standards for Communicating with Detainees with Limited English Proficiency in Medical Settings

The 2011 PBNDS section 4.3 on medical care requires facilities to provide appropriate interpretation and language services for detainees who are limited in their English proficiency regarding their medical and mental health care. When appropriate staff interpretation is not available, facilities must make use of professional interpretation services. Facilities must post information in English, Spanish, and other languages spoken by a significant segment of the facility's detainee population in medical intake areas about what language assistance is available during any medical or mental health consultation.

OIDO interviewed the acting Health Services Administrator (HSA) and reviewed 12 medical records chosen at random out of 62 available in the facility's electronic medical records system. OIDO found that all 12 medical records contained documentation regarding the use of language interpretation and translation services. OIDO interviewed two nurses and found that they were familiar with the process for the use of interpretation services. OIDO also observed that all examination rooms were equipped with a landline telephone to access interpretation services, and each room included postings with the language line phone number and instructions for how to access interpretation services.

The Facility Complied with Standards for Mental Health Screening and Evaluation

The 2011 PBNDS section 4.3 on medical care requires facilities to provide an initial medical, dental, and mental health screening performed by a qualified provider to each arriving detainee. This screening must be performed as soon as possible, but no later than 12 hours after arrival. In addition, a qualified health care provider must conduct an evaluation of any detainee referred for mental health treatment no later than 72 hours after referral, or sooner if necessary. Each facility must provide sufficient medical staff and support personnel to meet these standards.

OIDO interviewed the acting HSA and the Regional Director of Health Services and learned CCCC used telehealth to provide access to psychiatric services. Licensed professional counselors completed mental health evaluations either on-site or via a telehealth connection. OIDO reviewed

12 medical records selected randomly from the 62 records for ICE detainees currently in the facility. The records showed that all detainees had received an initial mental health screening within 12 hours of arrival. In addition, each of the seven resulting detainee referrals were seen by a qualified mental health provider within 72 hours.

B. Resolved Areas of Initial Non-Compliance

The Facility Did Not Maintain Clean and Sanitary Conditions in the Unit Used to House ICE Detainees

The 2011 PBNDS section 1.2 on environmental health and safety requires all facilities to maintain sanitation and cleanliness at the highest level. Facility administrators must ensure that staff and detainees maintain a high standard of facility sanitation and general cleanliness.

At the time of OIDO's inspection, all ICE detainees were housed in Unit 100. That housing unit was divided into four pods, labeled A, B, C, and D. OIDO was unable to observe pods A, B, and C in Unit 100, because they were being used to house detainees who had tested positive for coronavirus disease 2019 (COVID-19). OIDO did assess conditions in Unit 100, pod D; however, and observed unsanitary conditions in the shower, toilet, and sink areas due to inadequate cleaning procedures. Specifically, OIDO noted that the shower and sink drains had significant buildups of hair and soap scum. Moreover, OIDO observed dirt and debris in the toilet and sink areas.

OIDO discussed the conditions in housing Unit 100, pod D with the Acting Warden, and on August 10, 2022, the facility corrected the conditions in the shower, sink, and toilet areas to an acceptable standard of cleanliness. Clean and sanitary conditions were maintained in housing Unit 100, pod D for the remainder of the inspection.

Blocked Drainage Pipe Created Potential Safety Hazard

The 2011 PBNDS section 2.4 on facility security and control requires each facility to establish a comprehensive security inspection system that addresses every area of the facility, specifically including the perimeter fence line. The facility must conduct frequent unannounced security inspections on day and night shifts, in part to ensure facility safety, security, and good order; maintain sanitary standards; and eliminate fire and safety hazards. Officers who execute these security checks are required to submit maintenance requests as needed when issues are identified.

During its inspection, OIDO observed a blocked bio-swale drainage pipe between the parking lot and the main security entrance, causing a large amount of standing water. The drainage pipe was blocked for all three days of the inspection. The large pool of standing water was both a potential biological hazard, as a breeding ground for mosquitos, and a potential safety hazard for personnel entering and exiting the facility (*See* Exhibit 1).

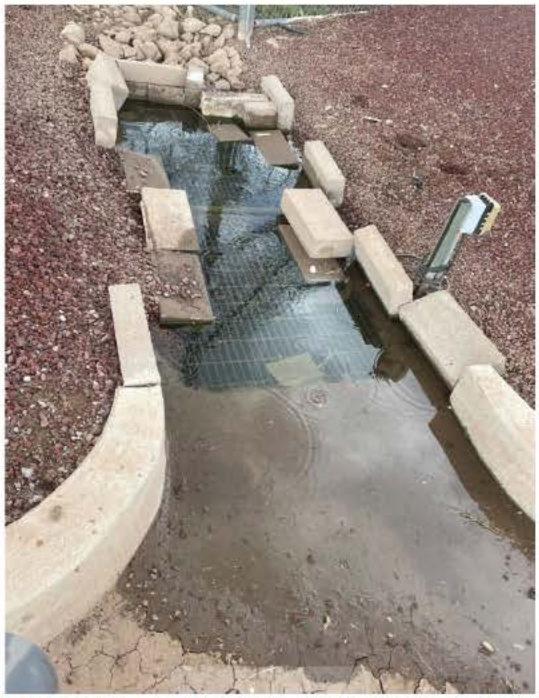

Exhibit 1. Blocked Bio-Swale Drainage Pipe and standing water between the parking lot and main security entrance at CCCC, as OIDO observed on August 11, 2022.
Source: OIDO

Following the inspection, the facility's maintenance supervisor reported that the drain had been cleaned out and provided photo evidence of the corrective action. OIDO finds this action sufficient to address the compliance deficiency.

C. Areas of Non-Compliance

The Facility Did Not Complete Monthly Inspections of Fire Extinguishers

The 2011 PBNDS section 1.2 requires every facility to develop a written fire prevention, control, and evacuation plan that includes inspection, testing, and maintenance of fire protection equipment in accordance with National Fire Protection Association (NFPA) codes. The NFPA codes require fire extinguishers to be inspected monthly.[5] OIDO inspected six fire extinguishers and found that three had not been inspected monthly as the PBNDS requires. Each of the fire extinguishers had been inspected in June 2022; however, they were not inspected in July 2022. These extinguishers were in the administrative corridor, in the locked Kosher Kitchen, and in the warehouse across from the walk-in freezer. Failure to routinely inspect fire safety equipment could potentially result in equipment failure during an emergency.

Documents Used During the Admission and Release Process Were Completed Incorrectly

The 2011 PBNDS section 2.1 requires a properly completed Order to Detain or an Order to Release (Form I-203 or I-203a), bearing the appropriate ICE ERO Authorizing Official signature, must

[5] *See* Guide to Fire Extinguisher Inspection, Testing and Maintenance | NFPA.

accompany each newly arriving detainee. OIDO randomly selected[6] and reviewed nine of the 29 available detainee files and found that four detainees had been admitted to the facility with a Form I-203 where "Release" was recorded instead of "Detain." Although the detainees were being processed for detention at the facility, the records reflected that they were being released. OIDO also reviewed five of the 44 available detention files for detainees who had been released from the facility and found each Form I-203 was completed correctly.

ICE ERO did not appear to be consistently reviewing each Form I-203 for completeness and correctness. Failure to ensure that the Form I-203 is completed correctly could result in a detainee being released from custody in error.

The Facility Did Not Properly Monitor Detainee Movement or Lock Food Carts

The 2011 PBNDS section 2.4 on facility security and control requires facility staff to observe, supervise, and control the movement of detainees from one area to another. A CoreCivic Operations Memorandum dated June 17, 2021, outlines specific procedures to better monitor detainee movement. On two occasions, OIDO observed unescorted U.S. Marshals Service inmates deliver food service carts to ICE detainee pods in housing Unit 100.

In addition, the 2011 PBNDS section 4.1 requires that when food carts are delivered to housing units by detainees, they must be locked unless they are under constant staff supervision. During the two incidents noted above, OIDO observed that one of the food carts delivered to an ICE detainee pod in housing Unit 100 did not have a functioning locking mechanism and was unsecure and another was unlocked (*See* Exhibit 2).

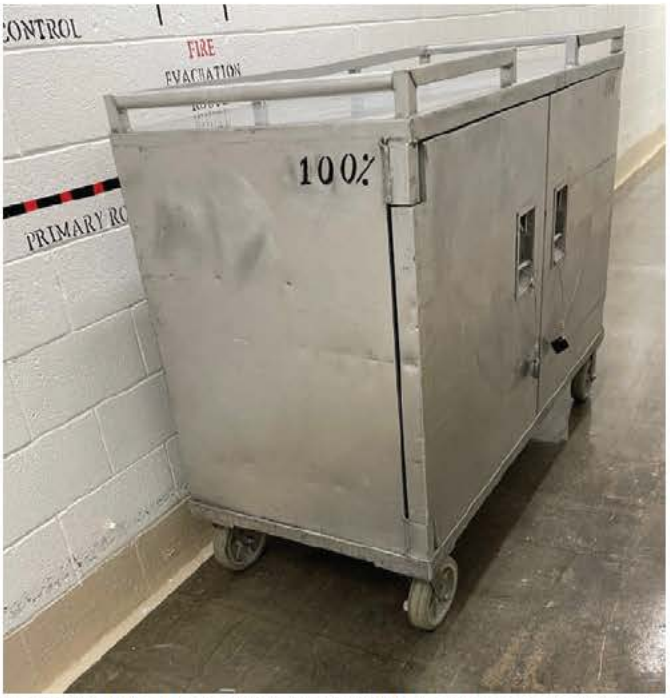

Exhibit 2. Unlocked and unescorted food cart with inoperable locking mechanisms, as OIDO observed on August 10, 2022.

[6] OIDO selected every third detention file of the available 29 files.

Source: OIDO

Senior facility managers stated that the facility supervised the movement of the food service carts via security cameras monitored in the Control Room. Surveillance via video is not sufficient, as the 2011 PBNDS section 2.4(V)(D)(2), Supervision and Communication, provides: "staff shall observe, supervise and control movement of detainees from one area to another. No detainee may ever be given authority over, or be permitted to exert control over, any other detainee" (pg. 86). Failure to supervise the detainees and the movement of food service carts by inmates or detainees could allow the introduction of contraband or contamination of the food.

ICE ERO Did Not Maintain Proper or Consistent Documentation for Informal Visits, Detainee Grievances, and Telephone Serviceability

The 2011 PBNDS section 2.13 on staff-detainee communication requires the facility to provide frequent opportunities for informal avenues of communication between facility staff, ICE ERO staff and detainees. Detainees must be able to submit written questions, requests, grievances, and concerns to ICE ERO staff and receive timely responses. Staff must record specific information regarding all detainee requests in a logbook specifically designed for that purpose and properly file and retain copies of all completed requests. This recorded information should include date of receipt, detainee name, detainee alien number, nationality, name of staff who logged the request, date the request with staff response was returned to detainee, any other pertinent site-specific information, specific reasons why a detainee's request is urgent and requires a faster response, the date the request was forwarded to ICE ERO and the date it was returned. A copy of each completed detainee request shall be filed in the detainee's detention file and be retained for a minimum of three years.

OIDO reviewed the electronic log that listed the written detainee requests for the period between January 1, 2022, and the date of OIDO's inspection. OIDO found that the log did not contain the required information for each detainee request and that ICE ERO did not maintain copies of the requests. Failure to maintain complete documentation of detainee requests and responses could result in delays in identifying and addressing substantiated complaints.

The 2011 PBNDS section 2.13 also states that ICE ERO staff must be available for informal interaction with detainees. ICE ERO guidance distributed via email on October 12, 2021, reminded Deportation Officers to sign logbooks when visiting with detainees in the housing units at the facility. OIDO reviewed the housing logbook for a period of 60 days prior to OIDO's inspection to determine whether ICE ERO officers were performing housing visits. OIDO found that the SMU Daily Logbook did not contain any records showing that ICE ERO officers had visited the housing unit. Inconsistent ICE ERO officer visits to housing units could hinder efforts to respond to detainee issues.

Finally, the 2011 PBNDS section 2.13 states that Field Office Directors shall ensure that all phones for detainee use are tested at least weekly in accordance with standard "5.6 Telephone Access." Staff shall report any telephone serviceability problem within 24 hours to the appropriate ICE point of contact. Staff shall document each serviceability test on a form that ICE ERO has provided. OIDO reviewed Facility Liaison Visit Checklists as well as the Telephone Serviceability Worksheets and found that ICE ERO maintained incomplete documentation of telephone

serviceability checks. OIDO found that ICE ERO did not have any records of serviceability testing between May 19 and August 2022.

Inconsistent ICE ERO officer telephone serviceability checks could inhibit efforts to identify and repair inoperable equipment in a timely manner.

The Facility Health Services Permanent Staffing Level Was Below Contract Requirements

The 2011 PBNDS section 4.3 on medical care requires all facilities to provide medical staff and sufficient support personnel to meet the standards. CCCC's Intergovernmental Service Agreement (IGSA) and 2022 Operational Staffing Pattern specifies 38.69 full-time equivalents (FTE) as the target for health services staffing. OIDO found that 14 out of the 38.69 FTEs for health services were vacant at the time of OIDO's inspection, resulting in a roughly 36 percent vacancy rate. OIDO reviewed a copy of the nursing staff schedule for August 2022. The facility had brought in three temporary duty and 13 agency nurses to fill the staffing gap. The facility also used telehealth services to provide detainees with health care services. While these measures temporarily address concerns with staffing levels, they do not provide a long-term solution. OIDO found that the 14 vacant positions had been posted on CoreCivic's website for permanent employment.

The Acting Warden reported that the facility had difficulty recruiting and retaining health services staff due to regional competition with two state prison systems (within 30 miles) offering higher wages. Recruitment of health services personnel may remain difficult due to the distance between CCCC in Milan, New Mexico, and regional major metropolitan areas such as Albuquerque, New Mexico, located 80 miles away. Nonetheless, having a fully staffed health services department is necessary to provide a continuum of health services without interruption.

The Facility Did Not Maintain Complete Credentialing Documentation for Health Services Personnel

The 2011 PBNDS section 4.3 on medical care requires facility health care personnel to perform duties within the scope of practice for which they are credentialed by training, licensure, and certification. The standard requires all health care staff to be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. The records documenting these credentials and licensure must be maintained onsite and be readily available for review.

OIDO reviewed the personnel files in the personnel binder for six licensed independent providers (LIPs), 11 registered nurses (RNs), 11 licensed practice nurses (LPNs), one medical record technician, and one dental assistant, for a total of 30 records. OIDO also identified five nurses and three LIPs listed on the nursing station assignment board who did not have files in the personnel binder.

OIDO reviewed the personnel files in the personnel binder and found the following gaps in credentialing documentation:

- Seven of the eight LIP files reviewed did not have primary source verification located in their personnel folders, and four out of eight LIPs did not have records of current National Practitioner Data Base (NPDB) searches in their personnel folders. In addition, three LIPs appeared on the assignment board but did not have files in the personnel binder.

- None of the 27 nurse files reviewed had NPDB searches in their personnel binder. Three of the 14 RNs and two of the 13 LPNs did not have licensure or basic life support documentation in the personnel binder; however, the acting HSA provided this information after OIDO's review of the files. In addition, five nurses appeared on the assignment board but did not have files in the personnel binder.
- The acting HSA did not have any credentialing information in the personnel binder.

At the time of inspection, the facility had a 36 percent vacancy rate, including a formal HSA and Nurse Manager; OIDO found 14 open positions in the health services department. Three temporary duty nurses and 13 agency nurses were contracted to work at CCCC to support this vacancy, but limited documentation was available as to these nurses in the personnel binder. Low staffing levels, including higher level administrative positions, contributed to the lack of documentation available for medical staff. Nonetheless, maintaining complete and up-to-date credentialing files is critical to ensure that all practicing licensed medical staff have appropriate licenses, credentials, education and training to perform their duties.

Health Services Personnel Did Not Complete Mandatory Staff Annual Training

The 2011 PBNDS section 7.3 on staff training requires the facility to provide appropriate initial and annual training to all employees. The standard lists the minimum requirements for initial and annual employee training, separated by specific job requirements.

OIDO interviewed the acting HSA and reviewed copies of the training logs for 14 staff members. OIDO reviewed the records to determine whether facility staff had completed annual training in the following areas: detainee grievance processing, hunger strikes, cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) training, suicide prevention and intervention, and Prison Rape Elimination Act (PREA) requirements. Out of the 14 training logs reviewed, three personnel had not completed mandatory annual training within the last 12 months. In addition, OIDO found that there were no training logs at all for 13 nursing personnel and eight LIPs.

The vacancy rate of 36 percent for health services at CCCC was relatively high, and, according to the current staffing plan, these vacancies were often in key nursing, administrative, and senior leadership positions, such as RNs and the Health Services Administrator. OIDO found that the facility used temporary duty or agency staff to fill these vacant positions on a short-term basis, but the constant rotation of personnel inhibited the establishment of consistent operations. In the case of annual training, the responsibility of scheduling and tracking annual training was not assigned to a single person. As such, completion of training was inconsistent across staff.

Training is important so that staff are equipped with the knowledge, skills, and demeanor to perform their duties well and with respect for the rights and dignity of detainees. Detention facility work is complex and requires a variety of skills. Many new staff members will not have any prior knowledge of detention facility standards, policies, and procedures. Training is thus part of developing and maintaining a skilled, motivated, and committed facility staff workforce. Annual training is necessary to maintain a safe and secure environment, including efficient operations.

The Facility Did Not Complete Annual Peer Review of All Independently Licensed Medical Professionals

The 2011 PBNDS section 4.3 on medical care requires the facility HSA to implement a peer review program for all independently licensed medical professionals, which includes the evaluation of professional work by others in the same field. Peer reviews must be conducted at least annually.

OIDO reviewed the personnel binder that held individual personnel files and found that out of eight LIPs, six did not have documentation demonstrating that a peer review had been conducted during the current year. In addition, none of the 11 RNs and 11 LPNs had any documentation showing that a peer review had ever been completed.

OIDO also reviewed the August 2022 nursing schedule, which showed a total of 14 RNs and 13 LPNs had been scheduled to work that month. Of these, three RNs and two LPNs did not have personnel files maintained in the personnel binder. Further, the schedule listed three LIPs who did not have any documentation in the personnel binder, including evidence that an annual peer review had been conducted.

At the time of OIDO's inspection, the facility's health services vacancy rate was 36 percent. Moreover, the facility did not have a permanent person assigned to the leadership position in the health services clinic at the time of its inspection. While the facility used temporary duty personnel to fill these positions on a short-term basis, the lack of permanent staff may help account for the failure to complete annual peer review of all independently licensed medical professionals.

Peer review in the medical field provides a mechanism for an organization to review its system of quality control related to its application of professional accounting, auditing, and attestation standards. Peer review will strengthen quality control and improve processes and correct any shortcomings. Peer review ensures the quality of care through safe deliverance of standards of care and newly discovered evidence-based practices.

The Facility Did Not Maintain Documentation for Quarterly Meetings and Internal Reviews

The 2011 PBNDS section 4.3 for medical care requires the facility to hold an administrative meeting quarterly at minimum, conducted by the facility HSA and including other facility and medical staff as appropriate. Meeting minutes must be recorded and kept on file. In addition, the facility HSA must implement a system to complete internal reviews, quality assurance reports, and continuous quality improvement projects. The system must collect and analyze data and information from the facility's operations and monitor health service outcomes on a regular basis.

OIDO interviewed the acting HSA, who was assigned to the facility in May 2022. OIDO requested copies of meeting minutes from the quarterly administrative meetings as well as any internal review or quality assurance documentation. The facility did not provide any documentation to show compliance with the PBNDS standards regarding quarterly meetings, internal review, quality assurance, or continuous quality improvement.

At the time of OIDO's inspection, the facility's health services vacancy rate was 36 percent. Moreover, the facility did not have a permanent person assigned to the position of HSA at the time of its inspection. The lack of a permanent staff member in this position may account for the failure to complete or maintain documentation for quarterly meetings and internal review.

When working in a detention facility environment, communication is key to the success of the organization. Administrative meetings are held to align goals, evaluate performance, discuss facility issues, policy development/updates, and provide information to vested parties, including senior administrator, compliance officers, and employees. Without these administrative meetings, the facility can be operating inefficiently and can jeopardize the safety of personnel and detainees.

A healthcare organization needs to have continuous quality improvement (CQI) programs to improve outcomes for health care in the detainee population. This information allows health services personnel the opportunities to improve efficiency and eliminate waste. CQI will monitor and track compliance with clinical practice guidelines and degree of control for multiple chronic conditions, *e.g.*, diabetes, hypertension, high cholesterol, and asthma. In addition, CQI can capture any areas of weakness to meeting the 12 hours limit on intake screenings, making sure comprehensive health assessment are completed within 14 days, and mental health evaluation are done timely. Without a CQI program, there are multiple opportunities for health services to be ineffective and potentially having a negative impact on the detained population.

The Facility Did Not Secure Detainee Medical Information

The 2011 PBNDS section 4.3 on medical care requires facility staff to protect the privacy of detainee medical information as per established guidelines and laws, including the Health Insurance and Portability Act (HIPAA). OIDO observed documentation containing personally identifiable information (PII) sitting on top of boxes outside the door to the pharmacy that facility staff delivered to the health services department. The delivery contained medication from the mail-order pharmacy, and the accompanying paperwork included detainee names and their assigned medications. OIDO did not observe any nursing staff or administrative personnel in the area (*See* Exhibit 3).

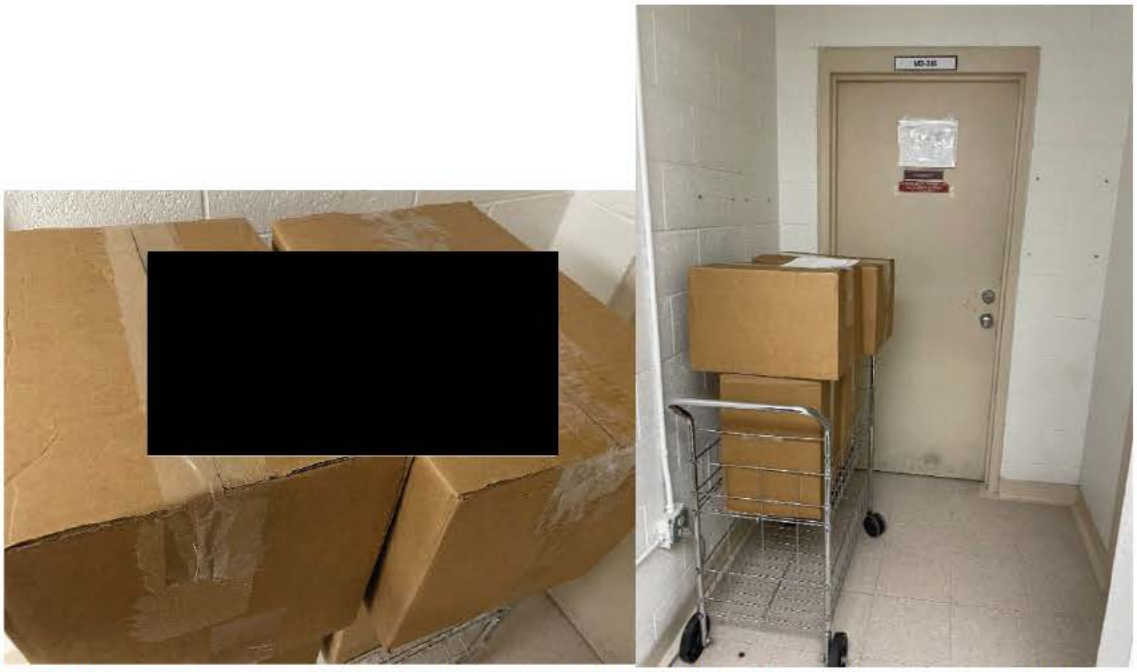

Exhibit 3. Pharmacy documentation containing personally identifiable information in an open hallway outside the door to pharmacy, as OIDO observed on August 11, 2022.

Source: OIDO

OIDO also reviewed the assignment board dated August 9, 2022, posted in hallway outside of nursing station in front of administrator's doorway. The board did not contain any guidance regarding who was responsible to respond to medical deliveries. The acting HSA indicated that there was a nurse assigned to the pharmacy areas; however, neither the schedule nor assignment board included information about who held this assignment.

At the time of OIDO's inspection, the facility had a medical staff vacancy rate of 36 percent. Several of these vacancies were in key administrative and leadership positions. While the facility used temporary duty personnel to fill these positions on a short-term basis, the lack of permanent staff may help account for the inadequate oversight and administration of pharmacy deliveries. Having a maximally staffed health services department provides for a continuum of uninterrupted health services and responsible facility administration. Protecting detainees' private information is necessary to maintain their trust and ensure that they feel comfortable seeking medical care.

The Facility Did Not Secure Mail Ordered Medications

The 2011 PBNDS section 4.3 on medical care requires the facility to store all pharmaceuticals in a secure storage area that includes the following: a secure perimeter; access to limited authorized medical staff, solid walls, a solid core entrance door with a high security lock; and a secure medication storage area.

OIDO interviewed the acting HSA regarding the facility's storage of pharmaceuticals. The acting HSA showed OIDO the area for medication storage, which was secured behind a locked door. While walking through the medical department, OIDO observed four boxes of medications sitting on a cart in front of the door to the pharmacy area, located inside the nursing station. OIDO did not observe any nursing staff or administrative personnel in the area.

The acting HSA also reported the facility had assigned a nurse to cover the certified medication assistant position, which was vacant at the time of inspection. However, OIDO observed the certified medication assistant designation was not listed on the assignment board or on the nursing August 2022 schedule. Failure to clearly assign the responsibility of storing all pharmaceuticals in a secure area may have attributed to the oversight regarding the four unsecured boxes on the cart outside the pharmacy seen during OIDO's inspection.

It is important to securely store pharmaceuticals to ensure medication remains in an appropriate environment, to include temperature and humidity controls and ensure that medications are not accessible to unauthorized personnel.

The Facility Did Not Distribute Prescribed Medication in a Timely Manner

The 2011 PBNDS section 4.3 on medical care requires all prescribed medications and medically necessary treatments to be provided to detainees on schedule and without interruption, absent exigent circumstances. OIDO interviewed the acting HSA and two nurses about the facility's pill line procedure for medication distribution. OIDO also reviewed 12 randomly selected medical records and found that one detainee did not receive the medication ordered by the LIP until 23 days after the detainee had been seen, though the medication prescribed would have been maintained onsite and the detainee should have received it within 24 hours.

At the time of OIDO's inspection, the facility's medical staff vacancy rate was 36 percent. The facility was in the process of hiring personnel to fill many of these positions, including an HSA and medical records technician, who were scheduled to start work shortly after OIDO's inspection. While the facility used temporary duty personnel to fill these positions on a short-term basis, the lack of permanent staff may help account for the untimely medication distribution. Having a fully staffed health services department with qualified professionals provides for an uninterrupted continuum of health services.

The Facility Did Not Regularly Evaluate One Detainee's Prescribed Psychiatric Medications

The 2011 PBNDS section 4.3 requires the facility providers to develop an overall treatment and management plan for detainees who are referred for mental health treatment. In addition, detainees who are prescribed psychiatric medications must be regularly evaluated by an appropriate medical professional at least once a month. OIDO reviewed 12 medical records chosen randomly and found one instance where a detainee receiving prescribed psychotropic medication was not seen at least once per month and did not have a follow-up appointment scheduled.

At the time of OIDO's inspection, the facility's medical staff vacancy rate was 36 percent. The facility was in the process of hiring personnel to fill many of these positions, including an HSA and medical records technician, who were scheduled to start work shortly after OIDO's inspection. While the facility used temporary duty personnel to fill these positions on a short-term basis, the lack of permanent staff may help account for the untimely follow-up appointment scheduling. Having a fully staffed health services department with qualified professionals provides for an uninterrupted continuum of health services.

Updated List of Free Telephone Numbers Was Not Posted in Medical and Special Management Units

The 2011 PBNDS section 5.6 on telephone access requires the facility to ensure that detainees can make free calls to certain parties: the ICE ERO-provided list of free legal service providers; consular officials; the DHS Office of Inspector General (OIG); and the ICE OPR Joint Intake Center (JIC). The ICE ERO Field Officer Director shall ensure that all information is kept current and is provided to each facility. Moreover, the facility must post the updated lists in the detainee housing units.

OIDO inspected the Medical Unit and the SMU and observed that the free telephone call list was not posted in these units. OIDO found that both units used mobile telephone stands, which were moved to the detainee's location when requested. The free telephone number list was not posted on any of the mobile telephone stands. The lack of the required postings within the medical and special housing units impedes detainee access to legal service providers, consular officials, the DHS Office of the Inspector General, and the ICE OPR JIC.

The Facility Did Not Properly Manage or Label Hazardous Chemicals

The 2011 PBNDS section 1.2 on environmental health and safety requires every facility to establish a system for storing, issuing, using, and maintaining inventories of and accountability for hazardous materials, which must meet the Occupational Safety and Health Administration standards. Additionally, the standards require staff and detainees to have ready and continuous

access to the Materials Safety Data Sheets (MSDS) for any substances they may work with. The MSDS lists information relating to occupational safety and health for the use of various substances and products.

OIDO observed an unattended cleaning cart in housing Unit 100, outside of pod D. The cart contained uncontrolled cleaning chemicals and did not have an associated MSDS (*See* Exhibit 4). OIDO also observed the same type of cleaning carts unattended and unlabeled in the A, B, and C pods in housing Unit 100.[7] Without proper labeling or posted MSDS, OIDO could not determine whether these cleaning supplies were uncontrolled hazardous chemicals.

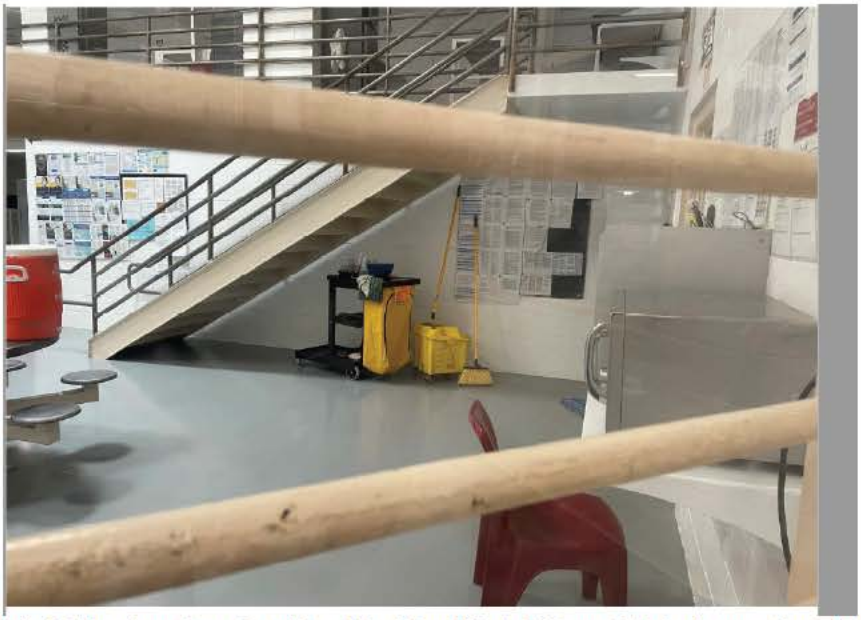

Exhibit 4. Unattended Cleaning Cart Outside of Pod D of Unit 100, as OIDO observed on August 9, 2022
Source: OIDO

Failure to properly manage and label hazardous chemicals can create risks to the health and safety of detainees and staff. Moreover, the lack of MSDS could result in delays in the provision of medical care should such materials be harmful.

The Facility Did Not Consistently Identify Vulnerable Populations During the Classification Process

The 2011 PBNDS section 2.2 on the custody classification system requires facilities to give special consideration to any factor that would raise the risk of vulnerability, victimization, or assault for a detainee. The classification process should incorporate requirements from the 2011 PBNDS section 2.11 on sexual abuse and assault prevention in the assessment of risk for victimization or perpetuation of sexual abuse or assault. The standards provide some examples of detainees who may be at risk that includes, but is not limited to, persons with disabilities, persons who are transgender, elderly, pregnant, suffering from a serious medical or mental illness, and victims of torture, trafficking, abuse, or other crimes of violence. Section 2.11 additionally identifies

[7] Though OIDO did not enter pods A, B, and C in housing Unit 100, the cleaning carts were visible through the windows from the corridor between the pods in housing Unit 100.

detainees who have self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming as among those who require special consideration.

OIDO reviewed a random sample of nine detainee detention files[8] and found that in three cases, the detainees were identified as members of a vulnerable population during the initial screening but were not identified as such on subsequent paperwork. In these cases, the Assessment Type, ICE Initial Screening Tool, that facility staff complete at time of admission,[9] identified each as a member of a vulnerable population. However, OIDO found that corresponding ICE Custody Classification Worksheet, completed during the 60-day reclassification review, did not reflect that these detainees were members of a vulnerable population.

At the time of the 60-day reclassification, ICE ERO and facility personnel involved with conducting the review failed to sufficiently review documents within the detention file. Agency and facility documentation relating to detainees with special vulnerabilities must be reviewed for consistency during subsequent reviews. Failure to do so could result in vulnerable detainees being placed in environments where they are exposed to potential threats.

Detainee Segregation Records Were Incomplete

The 2011 PBNDS section 2.12 on SMUs requires the facility administrator or designee to complete and approve a written order before a detainee is placed in administrative segregation. This administrative segregation order, documented on Form I-885 or equivalent, must detail the reasons for placing a detainee in administrative segregation. In an emergency, the detainee's placement in administrative segregation may precede completion of the paperwork, which the facility administrator or designee shall prepare as soon as possible after the detainee's SMU placement. In addition, the 2011 PBNDS section 4.6 on significant self-harm and suicide prevention and intervention allows staff to temporarily place suicidal detainees into administrative segregation cells in an SMU, provided space has been approved for this purpose by the medical staff and such space allows for constant and unobstructed observation.

At the time of inspection, CCCC had no detainees housed in the SMU. OIDO reviewed detainee segregation records from December 2021 to August 2022 and found inconsistencies in two cases. In one case, the detainee was housed in SMU for suicide watch in December 2021, but the detention file did not contain an Administrative Segregation Order. Therefore, OIDO could not confirm that medical staff had approved placement. In a second case, the Facility Administrator had not signed the detainee's Administrative Segregation Order.

Facility staff failed to complete necessary forms and facility management failed to ensure completeness and correctness of those forms. Failure to correctly complete required documentation could result in both the inappropriate initial and continued placement of a detainee in segregation.

[8] OIDO selected every third detention file of the available 29 files.
[9] The form is known as Form 14-2B, Assessment Questionnaire Information Form.

Conclusion

OIDO's inspection led to several findings, including 16 violations and three areas of concern. While the facility took early corrective action to address two of these deficiencies, several deficiencies persist. Complying with ICE's 2011 PBNDS and contract terms is essential to ensuring the health, safety, and rights of detainees. ICE must ensure that CCCC complies with the detention standards and contract terms and takes meaningful corrective action to address deficiencies.

Recommendations

Recommendation 1: For environmental health and safety, create and implement internal controls, training, and oversight that ensures:

(a) The facility inspects and tests all fire protection equipment on a routine basis as required; and

(b) The facility secures and monitors all carts containing hazardous materials used for cleaning functions and posts the associated MSDS on them.

Recommendation 2: For admission and release documentation, create and implement internal controls, training, and oversight that ensures that both ICE ERO and the facility correctly complete the appropriate documents during the admission and release process.

Recommendation 3: For detainee escorts, create and implement internal controls, training, and oversight that ensures facility staff know and adhere to proper escort procedures and policies.

Recommendation 4: For visitation, create and implement internal controls, training, and oversight that ensures all housing unit visits and telephone serviceability checks conducted by ICE ERO are documented in the appropriate logbooks.

Recommendation 5: For grievances, create and implement internal controls, training, and oversight that ensures all grievances addressed to the facility and or ICE ERO, are documented as required.

Recommendation 6: For medical care, create and implement internal controls, training, and oversight that ensures:

(a) Facility health services maintain complete credentialing documentation for health care personnel. This documentation must be readily available for review and demonstrate that personnel have been licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements;

(b) Facility health services complete annual peer review requirements for all independently licensed medical professionals;

(c) Facility health services conduct and document quarterly administrative meetings, internal reviews, and quality improvement activities and meetings;

(d) Facility behavioral health services adequately monitor detainees prescribed psychotropic

medications at least monthly;

(e) Facility health care personnel complete all mandatory annual staff training; and

(f) The facility takes the necessary steps to reach and maintain a sufficient level of health services staffing to comply with the requirements of the 2022 Operational Staffing Pattern, to include filling the vacancy for a certified medical assistant.

Recommendation 7: Ensure that the List of Free Telephone Numbers is posted in all areas, as required by policy and standards.

Recommendation 8: Create and implement internal controls, training, and oversight that ensures all documents generated for detainees identified as being a member of a vulnerable population during intake is reflected in subsequent documentation produced throughout their detention.

Recommendation 9: For segregation, create and implement internal controls, training, and oversight that ensures that facility correctly complete all documentation required for the placement of detainees in any form of segregation.

Response from Inspected Component and OIDO Analysis

ICE officials concurred with all nine recommendations and identified corrective actions to address the issues identified during the OIDO inspection. Based on ICE's initial and subsequent responses, OIDO considers all recommendations closed. Below is a summary of ICE's response and OIDO's final analysis of each response.

Component Response to Recommendation 1: ICE concurs with this recommendation. To ensure compliance with the monthly fire extinguisher inspection, the Facility Safety Manager submits Form 8-6B, which lists all the extinguisher locations in the facility and documents the dates of individual inspections to the Warden each month for review.

The Safety Data Sheet (SDS) for the BH-38 floor cleaner was added to the SDS manual in the Control Room and affixed to the unit cleaning carts to ensure that staff and detained noncitizens have continuous access to the SDS. In addition, the cleaning carts are secured in the storage area by unit staff when not in use.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers this matter addressed and closed.

Component Response to Recommendation 2: ICE concurs with this recommendation. If the facility receives an incorrect I-203 form during the admission and/or release process, the Records Department is requesting the proper I-203 form from ICE officials. ERO Supervisory Detention and Deportation Officers review all I-203s before detained noncitizens arrive at the facility. If concerns are found, then requests for corrections are made to the sending office. ERO officers also review all documentation prepared and provided by the facility before the noncitizens are transferred released or paroled.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers this matter addressed and closed.

Component Response to Recommendation 3: ICE concurs with this recommendation. Facility management updated the housing unit Post Orders to reflect that all ICE detained noncitizens are escorted and monitored to their assigned program/appointments by facility security staff. All staff working within the unit have been informed of the Post Order changes. Please refer to the attached Housing Unit document, *Housing Unit General Order*, which set forth escort procedures and policies.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers this matter addressed and closed.

Component Response to Recommendation 4: ICE concurs with this recommendation. ICE officers complete logs that are uploaded into a facility folder that is monitored by ICE only. ICE officers have been advised to log all housing unit visits into facility logs. The facility checklist is completed each week by ERO officers, including telephone serviceability checks.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers this matter addressed and closed.

Component Response to Recommendation 5: ICE concurs with this recommendation. ICE officers have created a log that is monitored and maintained by ICE personnel only.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers this matter addressed and closed.

Component Response to Recommendation 6: ICE concurs with these recommendations.

Component Response to Recommendation 6(a): For recommendation 6(a), new binders, which contain all required ICE postings, including telephone numbers, were placed in Restrictive Housing Units (RHUs) and the medical unit. RHU staff received training on the process, which is documented on a 4-2A Training Activity/Attendance Roster Form. All newly hired employees on or after December 15, 2022, who require credentialing will be added to the tracking system and have their credentialing packet, state licenses, National Practitioner Data Bank, and CPR licenses placed in the credentialing file within 30-days of commencing on-the-job training in the clinic. The Quality Assurance (QA) Department will be notified of this corrective action plan (CAP) step via the monthly report submitted in a previous step. Employees due for licensure updates and/or recredentialing will be notified via email 30-45 days prior to their expiration dates(s) so that the documentation can be collected and filed in a timely manner. The Regional Health Services Director and QA Manager will be copied when notifying the employee of their pending recredentialing due date. This matter was completed by March 31, 2023.

OIDO Analysis: OIDO finds these actions to be responsive to recommendation 6(a) and considers this matter addressed and closed.

Component Response to Recommendation 6(b): For recommendation 6(b), the Health Services Administrator's office is designated as the location for maintaining peer review records. The Regional Health Services Director and facility QA Manager have been notified of this location.

A peer review tracking system will be created that includes all licensed health care personnel and, at a minimum, the following information: name, position, hire date, most recent peer review date,

credentials of person who completed the most recent peer review, and due date of next peer review.

A hard copy will be maintained on file with the facility peer review records. The tracking system will be reviewed at least monthly. The review will include printing, initialing, dating, and updating a hard copy in the facility credentialing records. Once completed, copies will be forwarded to the Regional Health Services Director and QA Manager between January and March 2023. This system was implemented on March 8, 2023.

All personnel who need updated peer reviews will be identified. Staff will be notified individually and in a staff meeting of their pending peer review. Due dates for the peer review documentation will be monitored and completed. Peer review files will be updated within seven days of receipt. Copies of staff meeting minutes where peer review requirements were discussed will be forwarded to the QA Manager as supporting documentation for the CAP. On or after December 15, 2022, all newly hired employees who require a peer review will be added to the tracking system and have their Peer Review completed in the time frame designated by policy. This matter was completed on March 8, 2023.

OIDO Analysis: OIDO finds these actions to be responsive to recommendation 6(b) and considers this matter addressed and closed.

Component Response to Recommendation 6(c): For recommendation 6(c), the Medical Administrative Assistant's office was designated as the specific location for maintaining meeting minutes. The Regional Health Services Director and facility QA Manager were notified of this location. The review meetings of Administrative, Continuous Quality Improvement (CQI), and Infectious Disease 2023 Quarter 1 data (January 2023 through March 2023) were scheduled in April 2023. A copy of the calendar event was forwarded to the Regional Health Services Director and the QA Manager as supporting documentation for the CAP. At least two CQI study topics to be evaluated were scheduled in 2023 Quarter 1 (January 2023 through March 2023).

For the asthma and hypertension clinics, the Regional Health Services Director, QA Manager, and Director of Health Services Audits & Accreditation were notified of the topics. The results of the CQI studies and complete 13-52A-4 Model for Improvement Report will be evaluated. Copies will be forwarded to the Regional Health Services Director, QA Manager, and Director of Health Services Audits and Accreditation. This matter was completed on April 5, 2023.

OIDO Analysis: OIDO finds these actions to be responsive to recommendation 6(c) and considers this matter addressed and closed.

Component Response to Recommendation 6(d): For recommendation 6(d), all patients on psychotropic medications are followed by psychiatrists and Qualified Mental Health Professionals. Depending on the patient's mental health history, the psychiatrist determines how often a patient is seen/monitored. The electronic medical record (EMR) allows psychiatrists to choose the timeframes the patient needs to be seen; therefore, the EMR notifies psychiatrists/schedulers what patients need to be seen on a monthly/weekly basis. Please refer to the attached Mental Health Monthly Follow-up Log spreadsheet referencing three patients on psychotropic medications and the follow-up appointments that have taken place or are upcoming based on the treatment plan established by the psychiatrist.

OIDO Analysis: OIDO finds these actions to be responsive to recommendation 6(d) and considers this matter addressed and closed.

Component Response to Recommendation 6(e): For recommendation 6(e), request a report from the Learning & Development Department for all Health Services employees with pending or overdue training needs related to grievances, CPR, hunger strikes, suicide prevention, and Prison Rape Elimination Act, and forward a copy of the report to the QA Department as supporting documentation for the CAP. As of December 31, 2022, assigned in-service training has been completed by all full time CoreCivic medical staff. Please refer to the attached Group Summary spreadsheet.

OIDO Analysis: OIDO finds these actions to be responsive to recommendation 6(e) and considers this matter addressed and closed.

Component's Response to Recommendation 6(f): For recommendation 6(f), meet with the facility medical recruiter to compare 2022 recruiting activities with new initiatives in 2023. Summarize the discussion and share with the Regional Health Services Director and the facility Human Resources (HR) Manager and copy the QA Manager as supporting documentation for the CAP. In addition to medical staff, this year the facility hired a Health Service Administrator, Clinical Supervisor, three Registered Nurses (RNs) (CQI Nurse), two Licensed Practical Nurses, and an as needed RN. Encourage staff to continue working as a team until the rest of the positions are filled. Obtain timelines from the Recruiting and HR Departments on all new health services applicants received after December 15, 2022. Monitor pertinent timeframes between the facility receiving completed applications and the applicant's decision to accept or decline the employment offer. Summarize data in table or spreadsheet format and forward to the Regional Health Services Director and the facility HR Manager, copying the QA Manager as supporting documentation for the CAP, at least twice a month, the last one received on May 9, 2023. The purpose is to identify areas that need additional support or attention. Continue utilizing registry/agency nurses to temporarily assist with clinic operations while the Recruiting and HR Departments process new applicants. Summarize registry/agency usage at least twice a month, the last one being received on May 9, 2023.

OIDO Analysis: OIDO finds these actions to be responsive to recommendation 6(f) and considers this matter addressed and closed.

Component Response to Recommendation 7: ICE concurs with this recommendation. New binders containing all required ICE postings, including telephone numbers, were placed in RHU and the medical unit. Please refer to the attached photographs.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers this matter addressed and closed.

Component Response to Recommendation 8: ICE concurs with this recommendation. The classification officers were trained on January 9, 2023, to review all documentation, including ICE's initial screening, to identify any special vulnerabilities or management concerns that may affect the detained noncitizen's custody determination. Any special vulnerability or management concern identified is placed into the facility Offender Management System (OMS), which is where alerts are documented. Please refer to the attached OMS screenshot (*OMS Alert Redacted*).

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers this matter addressed and closed.

Component Response to Recommendation 9: ICE concurs with this recommendation. Special Management Unit (SMU) staff will be trained that barring any exigent circumstances, a confinement order for Administrative Segregation will be issued by the Warden or his designee prior to placing an ICE detained noncitizen into SMU. In the case of an ICE detained noncitizen being placed in RHU for medical reasons, SMU staff will ensure that the confinement order for Administrative Segregation is issued by a medical professional. Training was conducted with SMU staff on December 20, 2022. A memorandum detailing this protocol was posted in the SMU office. Please refer to the attached memorandum, *ICE Detainee Placement,* and photograph displaying placement (attachment *ICE RHU Placement*.)

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers this matter addressed and closed.

Appendix A: Component Response

Office of the Director

U.S. Department of Homeland Security
500 12th Street, SW
Washington, DC 20536

U.S. Immigration and Customs Enforcement

May 30, 2023

MEMORANDUM FOR: David D. Gersten
Acting Ombudsman
Office of the Immigration Detention Ombudsman

FROM: Tae D. Johnson
Deputy Director and
Senior Official Performing the Duties of the Director
U.S. Immigration and Customs Enforcement

SUBJECT: Response to the Office of the Immigration Detention Ombudsman's April 28, 2023 Responding Memorandum Regarding the Draft Report, Cibola County Correctional Center, August 9-11, 2022 (Case No. 22-001054)

Purpose

This memorandum is in response to the Department of Homeland Security's Office of the Immigration Detention Ombudsman's (OIDO) April 28, 2023 response to the April 25, 2023 U.S. Immigration and Customs Enforcement (ICE) memorandum regarding the OIDO draft report, *OIDO Inspection of Cibola County Correctional Center, Milan, New Mexico.*

Background

ICE is a federal agency charged with enforcing the nation's immigration laws in a fair and effective manner. ICE identifies, apprehends, detains, and removes noncitizens who are amenable to removal from the United States. ICE Enforcement and Removal Operations (ERO) uses its immigration detention authority to effectuate this mission by detaining noncitizens in custody while they await the outcome of their immigration proceedings and/or removal from the United States.

ICE has important obligations under the U.S. Constitution and other federal and state laws when it determines that a noncitizen is subject to detention. ICE national detention standards ensure that detained noncitizens are treated humanely, protected from harm, provided appropriate medical and mental health care, and receive the rights and protections to which they are entitled.

ICE ensures detention facilities used to house ICE detained noncitizens do so in accordance with ICE national detention standards. These standards were developed in cooperation with ICE stakeholders, the American Correctional Association, and nongovernmental organizations, and were created to ensure that all noncitizens in ICE custody are treated with dignity and respect and provided appropriate care. Each detention center must meet a set of specified standards.

ICE's Response to OIDO's Recommendation

Recommendation 1: For environmental health and safety, create and implement internal controls, training, and oversight that ensures:

(a) The facility inspects and tests all fire protection equipment on a routine basis as required; and

(b) The facility secures and monitors all carts containing hazardous materials used for cleaning functions and posts the associated MSDS on them.

Response: ICE concurs with this recommendation. To ensure compliance with the monthly fire extinguisher inspection, the Facility Safety Manager submits Form 8-6B, which lists all the extinguisher locations in the facility and documents the dates of the individual inspections to the Warden each month for review.

The Safety Data Sheet (SDS) for the BH-38 floor cleaner was added to the SDS manual in the Control Room and affixed to the unit cleaning carts to ensure that staff and detained noncitizens have continuous access to the SDS. In addition, the cleaning carts are secured in the storage area by unit staff when not in use.

Recommendation 2: For admission and release documentation, create and implement internal controls, training, and oversight that ensures that both ICE ERO and the facility correctly complete the appropriate documents during the admission and release process.

Response: ICE concurs with this recommendation. If the facility receives the incorrect I-203 form during the admission and/or release process, the Records Department is requesting the proper I-203 form from ICE officials. ERO Supervisory Detention and Deportation Officers review all I-203s before detained noncitizens arrive at the facility. If concerns are found, then requests for corrections are made to the sending office. ERO officers also review all documentation prepared and provided by the facility before the noncitizens are transferred, released, or paroled.

Recommendation 3: For detainee escorts, create and implement internal controls, training, and oversight that ensures facility staff know and adhere to proper escort procedures and policies.

Response: ICE concurs with this recommendation. Facility management updated the housing unit Post Orders to reflect that all ICE detained noncitizens leaving their unit are escorted and monitored to their assigned program/appointments by facility security staff. All staff working within the unit have been informed of the Post Order changes. Please refer to the attached

Housing Unit document, *Housing Unit General Order*, which set forth these escort procedures and policies.

Recommendation 4: For visitation, create and implement internal controls, training, and oversight that ensures all housing unit visits and telephone serviceability checks conducted by ICE ERO are documented in the appropriate logbooks.

Response: ICE concurs with this recommendation. ICE officers complete logs that are uploaded into a facility folder that is monitored by ICE only. ICE officers have been advised to log all housing unit visits into facility logs. The facility checklist is completed each week by ERO officers, including telephone serviceability checks.

Recommendation 5: For grievances, create and implement internal controls, training, and oversight that ensures all grievances addressed to the facility and or ICE ERO are documented as required.

Response: ICE concurs with this recommendation. ICE officers have created a log that is monitored and maintained by ICE personnel only.

Recommendation 6: For medical care, create and implement internal controls, training, and oversight that ensures:

(a) Facility health services maintain complete credentialing documentation for health care personnel. This documentation must be readily available for review and demonstrate that personnel have been licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements;
(b) Facility health services complete annual peer review requirements for all independently licensed medical professionals;
(c) Facility health services conduct and document quarterly administrative meetings, internal reviews, and quality improvement activities and meetings;
(d) Facility behavioral health services adequately monitor detainees prescribed psychotropic medications at least monthly;
(e) Facility health care personnel complete all mandatory annual staff training; and
(f) The facility takes the necessary steps to reach and maintain a sufficient level of health services staffing to comply with the requirements of the 2022 Operational Staffing Pattern, to include filling the vacancy for a certified medical assistant.

Response: ICE concurs with this recommendation. For recommendation 6(a), new binders, which contain all required ICE postings, including telephone numbers, were placed in Restrictive Housing Units (RHUs) and the medical unit. RHU staff received training on the process, which is documented on a 4-2A Training Activity/Attendance Roster Form. All newly hired employees on or after December 15, 2022, who require credentialing will be added to the tracking system and have their credentialing packet, state licenses, National Practitioner Data Bank, and CPR licenses placed in the credentialing file within 30-days of commencing on-the-job training in the clinic. The Quality Assurance (QA) Department will be notified of this Corrective Action Plan

(CAP) step via the monthly report submitted in a previous step. Employees due for licensure updates and/or recredentialing will be notified via email 30-45 days prior to their expiration dates(s) so that the documentation can be collected and filed in a timely manner. The Regional Health Services Director and QA Manager will be copied when notifying the employee of their pending recredentialing due date. This matter was completed by March 31, 2023.

For recommendation 6(b), the Health Services Administrator's office is designated as the location for maintaining peer review records. The Regional Health Services Director and facility QA Manager have been notified of this location.

A peer review tracking system will be created that includes all licensed health care personnel and, at a minimum, the following information:

- Name;
- Position;
- Hire date;
- Most recent Peer Review date;
- Credentials of person who completed the most recent Peer Review; and
- Due date of next Peer Review.

A hard copy will be maintained on file with the facility Peer Review records. The tracking system will be reviewed at least monthly. The review will include printing, initialing, dating, and updating a hard copy in the facility credentialing records. Once completed, copies will be forwarded to the Regional Health Services Director and QA Manager between January and March 2023. This system was implemented on March 8, 2023.

All personnel who need updated Peer Reviews will be identified. Staff will be notified individually and in a staff meeting of their pending Peer Review. Due dates for the Peer Review documentation will be monitored and completed. Peer Review files will be updated within seven days of receipt. Copies of staff meeting minutes where Peer Review requirements were discussed will be forwarded to the QA Manager as supporting documentation for the CAP. On or after December 15, 2022, all newly hired employees who require a Peer Review will be added to the tracking system and have their Peer Review completed in the time frame designated by policy. This matter was completed on March 8, 2023.

For recommendation 6(c), the Medical Administrative Assistants Office was designated as the specific location for maintaining meeting minutes. The Regional Health Services Director and facility QA Manager were notified of this location.

The review meetings of Administrative, Continuous Quality Improvement (CQI), and Infectious Disease 2023 Quarter 1 data (January 2023 through March 2023) were scheduled in April 2023. A copy of the calendar event was forwarded to the Regional Health Services Director and the QA Manager as supporting documentation for the CAP. At least two CQI study topics to be evaluated were scheduled in 2023 Quarter 1 (January 2023 through March 2023).

For the asthma and hypertension clinics, the Regional Health Services Director, QA Manager, and Director of Health Services Audits & Accreditation were notified of the topics. The results of the CQI Studies and complete 13-52A-4 Model for Improvement Report will be evaluated. Copies will be forwarded to the Regional Health Services Director, QA Manager, and Director of Health Services Audits & Accreditation. This matter was completed on April 5, 2023.

For recommendation 6(d), all patients on psychotropic medications are followed by psychiatrists and Qualified Mental Health Professionals. Depending on the patient's mental health history, the psychiatrist determines how often a patient is seen/monitored. The electronic medical record (EMR) allows psychiatrists to choose the timeframes the patient needs to be seen; therefore, the EMR notifies psychiatrists/schedulers what patients need to be seen on a monthly/weekly basis. Please refer to the attached Mental Health Monthly Follow-up Log spreadsheet referencing three patients on psychotropic medications and the follow-up appointments that have taken place or are upcoming based on the treatment plan established by the psychiatrist.

For recommendation 6(e), request a report from the Learning & Development Department for all Health Services employees with pending or overdue training needs related to grievances, CPR, hunger strikes, suicide prevention, and Prison Rape Elimination Act, and forward a copy of the report to the QA Department as supporting documentation for the CAP. As of December 31, 2022, assigned in-service training has been completed by all full time CoreCivic medical staff. Please refer to the attached Group Summary spreadsheet.

For recommendation 6(f), meet with the facility medical recruiter to compare 2022 recruiting activities with new initiatives in 2023. Summarize the discussion and share with the Regional Health Services Director and the facility Human Resources (HR) Manager and copy the QA Manager as supporting documentation for the CAP. In addition to medical staff, this year the facility hired a Health Service Administrator, Clinical Supervisor, three Registered Nurses (RNs) (CQI Nurse), two Licensed Practical Nurses, and an as needed RN. Encourage staff to continue working as a team until the rest of the positions are filled. Obtain timelines from the Recruiting and HR Departments on all new health services applicants received after December 15, 2022. Monitor pertinent timeframes between the facility receiving completed applications and the applicant's decision to accept or decline the employment offer. Summarize data in table or spreadsheet format and forward to the Regional Health Services Director and the facility HR Manager, copying the QA Manager as supporting documentation for the CAP, at least twice a month, the last one received on May 9, 2023. The purpose is to identify areas that need additional support or attention. Continue utilizing registry/agency nurses to temporarily assist with clinic operations while the Recruiting and HR Departments process new applicants. Summarize registry/agency usage at least twice a month, the last one being received on May 9, 2023.

Recommendation 7: Ensure that the List of Free Telephone Numbers is posted in all areas, as required by policy and standards.

Response: ICE concurs with this recommendation. New binders containing all required ICE postings, including telephone numbers, were placed in RHU and the medical unit. These binders are available for use upon request by detained noncitizens. Please refer to the attached photographs.

Recommendation 8: Create and implement internal controls, training, and oversight that ensures all documents generated for detainees identified as being a member of a vulnerable population during intake are reflected in subsequent documentation produced throughout their detention.

Response: ICE concurs with this recommendation. The classification officers were trained on January 9, 2023, to review all documentation, including ICE's initial screening, to identify any special vulnerabilities or management concerns that may affect the detained noncitizen's custody determination. Any special vulnerability or management concern identified is placed into the facility Offender Management System (OMS), which is where alerts are documented. Please refer to the attached OMS screenshot (*OMS Alert Redacted*).

Recommendation 9: For segregation, create and implement internal controls, training, and oversight that ensures that facility correctly completes all documentation required for the placement of detainees in any form of segregation.

Response: ICE concurs with this recommendation. Special Management Unit (SMU) staff will be trained that barring any exigent circumstances, a confinement order for Administrative Segregation will be issued by the Warden or his designee prior to placing an ICE detained noncitizen into SMU. In the case of an ICE detained noncitizen being placed in RHU for medical reasons, SMU staff will ensure that the confinement order for Administrative Segregation is issued by a medical professional. Training was conducted with SMU staff on December 20, 2022. A memorandum detailing this protocol was posted in the SMU office. Please refer to the attached memorandum, *ICE Detainee SMU Placement*, and photograph displaying placement (attachment *ICE RHU Placement*).

Attachments

- Housing Unit General Order
- Mental Health Monthly Follow-up Log
- Group Summary Spreadsheet
- RHU Photo (1 of 2)
- RHU Photo (2 of 2)
- OMS Alert Redacted
- ICE Detainee SMU Placement
- ICE RHU Placement

Additional Information and Copies

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