OIDO
Office of the Immigration Detention Ombudsman

OIDO INSPECTION OF SOUTH LOUISIANA ICE PROCESSING CENTER

OIDO-24-004
August 2, 2024

Department of Homeland Security
Washington, DC 20528

OIDO
Office of the Immigration Detention Ombudsman

August 2, 2024

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

FROM: Michelle Brané
Ombudsman
Office of the Immigration Detention Ombudsman

MICHELLE N BRANE
Digitally signed by MICHELLE N BRANE
Date: 2024.08.02 14:59:45 -04'00'

SUBJECT: OIDO-24-004
South Louisiana ICE Processing Center
October 25–27, 2022

Attached is the Office of the Immigration Detention Ombudsman's final report based on its inspection of the South Louisiana ICE Processing Center (SLIPC) in Basile, Louisiana, on October 25–27, 2022. We reviewed SLIPC's performance as well as its compliance with the 2011 Performance-Based National Detention Standards, as revised in 2016 (hereinafter referred to as the 2011 PBNDS) and contract terms.

The report contains seven recommendations aimed at improving the facility and its compliance with the 2011 PBNDS and contract terms. Your office concurred with all seven recommendations provided herein. Based on information in your response to the draft report, we consider Recommendation 1 unaddressed and open, Recommendations 6(a) and 7 addressed and open, and the other recommendations addressed and closed.

Attachment

OIDO INSPECTION
OF
SOUTH LOUISIANA ICE PROCESSING CENTER
Basile, Louisiana

Executive Summary

In October 2022, the Office of the Immigration Detention Ombudsman (OIDO) conducted an unannounced inspection of the South Louisiana ICE Processing Center (SLIPC) in Basile, Louisiana. OIDO's inspection assessed compliance with the 2011 Performance Based National Detention Standards, as revised in 2016 (hereafter 2011 PBNDS). OIDO inspected SLIPC, in part, to follow up on deficiencies that other inspection entities previously identified. Specifically, OIDO examined issues related to staff–detainee communication, environmental health and safety, use of force, special management units, access to law library and legal counsel, correspondence and other mail, language access, telephone access, grievance system, and medical care, including review of the health care staffing plan.

OIDO's inspection led to 15 general custody and 20 medical findings. Of the findings related to general custody issues, 11 were compliant findings, and four were non-compliant. Of the findings related to medical issues, three were compliant findings, and 17 were non-compliant findings.

The non-compliant general custody findings included the following:

- a mosquito infestation,
- lack of posted Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) visitation schedule,
- lack of tool control, and
- failure to post munitions inventory list.

The non-compliant medical findings included the following:

- insufficient medical staffing levels,
- incomplete credential files,
- inadequate emergency response plan and training,
- improperly monitored negative-pressure isolation rooms,
- irregular emergency equipment and first aid kit checks,
- untimely and inadequately documented mental health assessments,
- lack of detainee privacy during telehealth sessions,

- untimely initial intake screenings, comprehensive health assessments, and sick call request responses,
- out-of-date instructions for requesting health care services,
- untimely mental health evaluations,
- inconsistent documentation of pregnancy testing results,
- lack of privacy in suicide watch cell,
- improper monitoring for detainees on suicide watch,
- inaccurate logging and untimely resolution of medical grievances, and
- inconsistent COVID-19 testing at intake.

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

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Office of the Immigration Detention Ombudsman

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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 Division conducts independent, objective, and credible inspections of Immigration and Customs Enforcement (ICE) owned and operated 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.

On October 25–27, 2022, OIDO conducted an unannounced inspection of the South Louisiana ICE Processing Center (SLIPC) to examine compliance with the 2011 Performance Based National Detention Standards as revised in 2016 (hereinafter referred to as 2011 PBNDS) and contract terms. OIDO focused on the following areas: staff–detainee communication, medical care, food service, telephone access, and grievance system.

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.[1] 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 well-being of detainees due to COVID-19.[2]

SLIPC is a contract detention facility located in a rural area on the outskirts of Basile, Louisiana. The Geo Group, Inc. (GEO) owns and operates the facility. ICE ERO has an intergovernmental services agreement (IGSA) with Evangeline Parish Sheriff's Office for the detention and care of detainees at SLIPC. The facility is under the oversight of ICE ERO's New Orleans Field Office. GEO provides food services and medical care, Union Supply Group[3] provides commissary services, and Talton Communications[4] provides telephone and tablet services at the facility.

SLIPC is under a shared services contract with its sister facility, Pine Prairie ICE Processing Center (PPIPC). In July 2019, SLIPC converted to housing only female detainees; that conversion became permanent in December 2019. In 2020, a modification to the IGSA incorporated a tiered staffing plan for SLIPC and PPIPC. The SLIPC staffing plan contains two sets of provisions: one for a guaranteed minimum of 700 beds and one for 1,000 beds. OIDO reviewed both staffing plans, which designate staffing requirements for both custody and health care staff. The 1,000-bed facility houses female ICE detainees of all classification levels. The facility had an average daily

[1] 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.
[2] ERO COVID-19 Pandemic Response Requirements (Version 10.0, November 1, 2022).
[3] *See* Union Supply Group.
[4] *See* Talton Communications.

population of 418 detainees in fiscal year 2022.[5] At the time of OIDO's inspection, the facility held 607 adult female detainees in ICE custody.

Prior to OIDO's October 2022 inspection, the following recent compliance inspections had been conducted at the facility. The ICE Office of Professional Responsibility Office of Detention Oversight (ODO) conducted compliance and follow-up inspections on April 12–16, 2021,[6] August 30–September 2, 2021,[7] and March 8–10, 2022.[8] During the April 2021 inspection, ODO assessed the facility's compliance with a total of 21 standards and found three deficiencies in two areas: one in admission and release and two in facility security and control. During the August 2021 remote inspection, ODO assessed the facility's compliance with a total of 13 standards and found two deficiencies in two areas: food service and medical care. Finally, during the March 2022 inspection, ODO assessed compliance with a total of 24 standards and found 11 deficiencies in seven areas: post orders, searches of detainees, use of force and restraints post orders, medical care, correspondence and other mail, marriage requests, detention files, and interview and tours.

In addition, the Nakamoto Group, Inc. conducted annual inspections of SLIPC for compliance with the 2011 PBNDS in December 2020[9] and November 2021.[10] In December 2020, Nakamoto assessed compliance with a total of 40 standards and found no deficiencies. In November 2021, Nakamoto assessed compliance with 41 standards and found one deficiency in food service.

In preparing for an inspection, OIDO reviews Case Management Division (CMD) case complaints to identify inspections topics. At the time of inspection, OIDO had one Case Manager assigned to the facility.

Objective, Scope, and Methodology

OIDO conducted an unannounced inspection of SLIPC. OIDO examined overall compliance with the 2011 PBNDS. Four medical specialists, five investigators, and one manager 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 15 general custody and 20 medical findings. Of the findings related to general custody issues, 11 were compliant and four were non-compliant. Of the findings related to medical issues, three were compliant and 17 were non-compliant. The findings are divided into two sections: areas of compliance and areas of non-compliance.

[5] *See* ICE FY 2022 Detention Statistics.
[6] *See* ODO Compliance Inspection South Louisiana ICE Processing Center April 12-16, 2021.
[7] *See* ODO Follow-up Compliance Inspection South Louisiana ICE Processing Center August 30-September 2, 2021.
[8] *See* ODO Compliance Inspection South Louisiana ICE Processing Center March 8-10, 2022..
[9] *See* Nakamoto Annual Inspection of the South Louisiana ICE Processing Center December 2020.
[10] *See* Nakamoto Annual Inspection of the South Louisiana ICE Processing Center November 2021.

A. Areas of Compliance

i. Custody Findings

The Facility Complied with Requirements for Post Orders

The 2011 PBNDS section 2.9 on post orders requires that each officer have current written post orders that specifically applies to the assigned post and includes step-by-step procedures written in sufficient detail to guide the officer. The facility must maintain records showing that the assigned officers read and understood the post orders. Further, the facility must formally review post orders annually and update as needed.

OIDO reviewed the facility's Post Order Annual Review Statement dated December 7, 2022, which showed that the facility had 30 post orders in effect at that time. OIDO reviewed the 30 orders and found that each one was current and contained the Facility Administrator's signature certifying that the order had received annual review. Further, OIDO reviewed acknowledgment sheets for a sampling of the post orders ranging from August to December 2022; these demonstrated that officers had acknowledged that they had read and understood the orders. In short, OIDO found that all post orders were current and that annual reviews had been conducted.

The Facility Complied with Requirements for Special Management Units

The 2011 PBNDS section 2.12 on special management units (SMUs) requires that facilities protect detainees, staff, and others from harm by segregating certain detainees from the general population. This standard contains provisions for separating detainees from the general population for administrative or disciplinary reasons.

OIDO also reviewed GEO Policy 10.4.1, Special Management Units for ICE Facilities, which aligned with and provided more detailed training requirements than the PBNDS. Both the 2011 PBNDS section 2.12 on SMUs and the GEO Policy 10.4.1 require that the facility establish an SMU to isolate certain detainees from the general population. The SMU is required to have two sections: administrative and disciplinary. In addition, the GEO policy requires that security staff assigned to the SMU shall receive specialized training in 11 relevant topics..[11]

According to the Chief of Security, the facility opened in 2019 and had never housed any detainees in SMU. OIDO observed that this facility did have dedicated areas for administrative and disciplinary segregation of detainees. OIDO reviewed the post orders for SMU housing officers and found they were current and were reviewed annually. In addition, OIDO reviewed a list of 24 employees who had completed the 2022 SMU training and were qualified to work in the SMU. OIDO reviewed staff training records and the online curriculum aligned with policy requirements.

The Facility Complied with Requirements to Conduct Semi-Annual Range Hood Fire Suppression System Inspections

The 2011 PBNDS section 4.1.V. J.12. (f) states that an approved, fixed fire-suppression system

[11] Required trainings include (1) identifying signs of mental health decompensation; (2) techniques for more appropriate interactions with mentally ill detainees; (3) the impact of isolation; (4) de-escalation techniques; (5) crisis intervention; (6) stress management; (7) managing behavioral health disorders; (8) search procedures; (9) application of restraints, escort procedures, use of force, and orderly supervision; (10) cell/unit housekeeping plans and sanitation expectations; and (11) emergency response procedures and overview of unit operations.

shall be installed in ventilation hoods over all grills, deep fryers, and open-flame devices. A qualified contractor shall inspect the system every six months. The facility Food Service Administrator (FSA) reported that the facility conducts semi-annual range hood fire suppression system inspections. OIDO reviewed two inspection reports for the range hood system dated March 26, 2022, and September 7, 2022. The reports showed that inspectors did not find any deficiencies with the range hood fire suppression system.

The Facility Complied with Requirements to Maintain and Annually Inspect Food Service Facilities and Equipment

The 2011 PBNDS section 4.1 on food service requires that an independent, external inspector conduct annual inspection of food service facilities and equipment to ensure they meet governmental health and safety codes. The facility administrator must establish the date by which identified problems will be corrected.

OIDO reviewed reports of the two most recent inspections of the facility's food service facilities. The State of Louisiana Department of Health completed the inspections on June 21 and October 7, 2022. The reports note that critical items must be corrected immediately, and non-critical items must be corrected prior to the next regular inspection. The June 2022 report noted one critical item, which was corrected during the inspection, and four non-critical items. The October inspection report noted one non-critical item.

The facility had a plan of action to correct the non-critical deficiencies. The facility received a Permit to Operate for 2022–2023, issued on May 23, 2022, from the Louisiana Department of Health. OIDO also reviewed all weekly safety/sanitation inspections and monthly inspections from the time frame of April 2022 to September 2022. OIDO determined the documents were completed as required by policy.

The Facility Complied with Requirements to Provide Specialized Food Service Training to Staff and Detainees

The 2011 PBNDS section 4.1 on food service requires that detainees, staff, and others must be protected from injury and illness by adequate food service training and application of safety and sanitation practices. GEO Policy No. 11.1.1, Food Service Operations, Section III, Standards and Procedures, (B) General Policy, paragraph 12 provides for detainee orientation and training. That provision states cook supervisors will instruct newly assigned detainee workers in the rules and procedures of the Food Service Department and provide an explanation and demonstration of safe work practices and methods. Supervisors must document training in the detainee's detention file.

OIDO reviewed training documentation for eight staff members assigned as cook supervisors and found that they had received the required training. The training files had either a ServSafe training certificate or a signed acknowledgment that the employee had received a copy of the GEO Group Food Service Manual. According to the FSA, each cook supervisor received specialized training on the job. OIDO reviewed one such training packet that documented when the staff member received each training session.

At the time of OIDO's inspection, the facility employed 32 detainees in food service as kitchen orderlies. OIDO reviewed training documentation for all 32 detainees and found that all had received the required training. For detainees who did not read English, a Spanish version of the training was available.

The Facility Complied with Requirements to Provide Nutritionally Balanced Diets

The 2011 PBNDS section 4.1 on food service requires that detainees be provided nutritionally balanced diets that are reviewed at least quarterly by food service personnel and at least annually by a qualified nutritionist or dietitian.

The FSA indicated that the facility used a six-week menu cycle. OIDO reviewed all menus created for a six-week cycle, including regular diet, common fare diet, medical diets, and Kosher requirements; all menus reviewed had electronic signatures and dates showing that a certified dietitian created and certified these special diet plans. Further, the FSA described the facility's procedures for offering special diets. OIDO found that the information that the FSA provided and the documents OIDO reviewed aligned with 2011 PBNDS section 4.1 requirements.

The Facility Complied with Requirements to Use Only Safe Materials to Sanitize the Food Service Department

The 2011 PBNDS section 4.1 on food service requires that facilities will use only those toxic and caustic materials required for sanitary maintenance of the facility, equipment, and utensils in the food service department.

The facility's FSA reported that GEO facilities received all chemicals used in food service through GEO Group corporate buying. OIDO found that staff members used 15 chemicals in the Food Service Department. OIDO reviewed each of the 15 chemicals and found that all were properly inventoried, labeled, and secured (*See* Exhibit 1). Further, OIDO found all Material Safety Data Sheets (MSDSs) for these chemicals were available in the SDS binder. OIDO reviewed the MSDSs for each chemical and determined that they were appropriate for usage in a food service setting.

Exhibit 1. Chemical storage areas for SLIPC's Food Service Department. Chemicals are in original manufacturer's containers, labeled with contents, and stored correctly (left); chemicals are in locked storage cabinet (right), as observed by OIDO on October 26, 2022.
Source: OIDO

The Facility Commendably Followed Proper Hygiene and Sanitation Practices in Food Service

The 2011 PBNDS section 4.1 on food service states all food service employees are responsible for maintaining a high level of sanitation in the Food Service Department. An effective sanitation program prevents health problems, creates a positive environment, and encourages a feeling of

pride and cooperation among detainees. The standard also requires food service staff to teach detainee workers personal cleanliness and hygiene; sanitary methods of preparing, storing, and serving food; and the sanitary operation, care, and maintenance of equipment, including automatic dishwashers and pot and pan washers.

OIDO observed the Food Service Department and found that overall sanitation in the food service area was commendable. Detainee dining areas and restrooms were clean and orderly. The kitchen area was well lit; floors, walls, dry storage areas, cold storage areas, the serving line, pot and pan storage, ovens, kettles, sinks, and food prep areas and machinery were all clean and well organized. OIDO observed staff and detainee workers "cleaning as they go" to ensure proper sanitation—meaning when a food preparation area was used, it was cleaned immediately afterward to keep the whole kitchen in a state of general cleanliness while preparing meals. OIDO observed that staff and detainee workers had proper food service uniforms. The uniforms were clean, and all workers wore effective hair restraints and gloves.

OIDO reviewed all 32 food service detainee worker files, which contained training certifications for food service work prior to detainees beginning food service duties. In addition, OIDO reviewed 18 Open and Closing Checklists dated between April and September 2022. OIDO selected three checklists randomly for each month. The checklists documented the general appearance and cleanliness of the kitchen equipment; temperatures of the dish washing machine, freezer, coolers, and dry storage; as well as whether any food service workers had reported symptoms of illness that would preclude them from working (e.g., fever, cough, chills, diarrhea). OIDO found these checklists were completed in full and showed temperatures were within acceptable ranges.

The Facility Complied with Requirements to Handle Cash Discovered in the Mail

The 2011 PBNDS section 5.1 on correspondence and other mail requires that detainees be able to correspond with their families, the community, legal representatives, government offices, and consular officials. For any cash that is discovered in the mail, a receipt shall be issued to the detainee, and the cash shall be safeguarded and credited to the detainee's account.

In November 2019, the Nakamoto Group, Inc. conducted a compliance inspection of the facility and found that a mailroom clerk had returned cash to the sender when cash had arrived by mail for a detainee, which was not in accordance with facility policy. During the inspection, OIDO found that the Facility Administrator had amended the facility's practices regarding receipt of cash by mail to meet the 2011 PBNDS by issuing receipts to both the detainee and sender, recording cash received in a logbook, and forwarding the cash and receipt to the Business Office for crediting to the detainee's account. OIDO reviewed SLIPC's Policy and Procedure Manual, No. 8.2.1, Detainee Correspondence and Inspection of Mail (effective October 14, 2021), and found that it included procedures to receipt, safeguard, and forward cash that had been sent to detainees and discovered in the mail.

The Facility Complied with Requirements to Provide Detainees with Telephone Access

The 2011 PBNDS section 5.6 on telephone access states that facilities must provide at least one operable telephone for every 25 detainees to ensure sufficient access. Each facility shall maintain detainee telephones in proper working order. Designated facility staff shall inspect the telephones daily and promptly report out-of-order telephones to the repair service so that required repairs are completed quickly.

OIDO reviewed a breakdown of the number of telephones and tablets available per unit that the facility provided. It showed that the facility had an overall ratio of nine telephones and tablets per 25 detainees at the time of inspection. OIDO randomly inspected five telephones in Housing Unit D and found that dial tones were present for each.

Further, the Supervisory Detention and Deportation Officer stated that the Deportation Officers are responsible for conducting weekly inspections of the housing units. OIDO reviewed four weekly Facility Liaison Visit Checklists and Telephone Serviceability Worksheets completed between September 28 and October 19, 2022. The worksheets reflected that ICE ERO conducted housing unit visits and checked the functionality of the tablets and telephones during this period. Finally, OIDO observed posters on the Intake Department bulletin board that provided telephone/tablet operational instructions and ICE ERO contact numbers to detainees.

The Facility Provided Detainees with Access to and Exceptional Service in Law Libraries and Legal Materials

The 2011 PBNDS section 6.3 on law libraries and legal materials requires that detainees are provided access to a properly equipped law library, legal materials, and equipment (including photocopying resources) to facilitate the preparation of documents.

OIDO observed that the library had 10 desktop computers for detainee use with access to legal research on the LexisNexis computer database system and a large supply of books that detainees could use while in the library or check out (*See* Exhibit 2). The library had a commercial printer that detainees could use to print legal and leisure reading material.

Exhibit 2. Law library's 10 desktop computers (left) and reading materials (right) for detainee use, as observed by OIDO on October 25, 2022.
Source: OIDO

OIDO reviewed the law library schedule, which showed the facility scheduled detainees in general population housing for up to 15 hours of law library use per week and the SMU population for five hours per week. The Librarian stated that she frequently made special accommodations when detainees could not visit the library at their regularly scheduled times. In addition, the Librarian stated that she accommodated requests from detainees for additional library time to allow them to work on their legal cases and was available to assist with printing and notary services upon request. The Librarian mentioned that she had a low supply of Russian-language reading materials but was working with a local vendor to secure additional reading materials/books for the facility's Russian-speaking detainee population. Overall, OIDO found that the Librarian made a commendable effort to ensure ICE detainees had access to the facility's law library and legal materials and services.

ii. Medical Findings

The Facility Complied with Requirements to Provide Female Detainees with Access to Age-Appropriate Health Care and Specialty Services

The 2011 PBNDS section 4.3 on medical care requires that every facility provide its detainee population with specialty health care. Section 4.4 on medical care for women requires the facility to provide female detainees access to routine, age-appropriate gynecological and obstetrical health care.

OIDO reviewed the current list of available off-site providers, which included hospitals and specialty care providers, as well as the off-site appointment logbook entries dated September 12 to October 28, 2022. OIDO selected five off-site referrals for review and determined all appointments were provided within a reasonable time frame of 45 days after the order was entered.

In addition, OIDO randomly selected and reviewed 13 intake screening records dated from July to October 2022 to determine whether the facility's intake questionnaire included questions to female detainees regarding breastfeeding, contraception, reproductive history, menstrual cycle, and breast and gynecological problems. OIDO found all 13 intake screenings reviewed showed that female detainees had been asked all required women's health questions.

OIDO also reviewed electronic medical records and found no detainees were pregnant at the time of the inspection. Therefore, OIDO reviewed medical records of two prior pregnant detainees and determined the facility had provided access to prenatal care and specialty services. While in custody, both pregnant females received prenatal vitamins, a high-calorie diet, and referrals to specialty care for an appointment with obstetrics/gynecology.

The Facility Complied with Requirements for Comprehensive Health Assessments Training

The 2011 PBNDS section 4.3 on medical care requires that a physician, physician assistant, nurse practitioner, or other health care practitioner as permitted by law, perform detainee physical examinations. Registered Nurses (RNs) may complete comprehensive health assessments (CHAs) with documented training provided by a physician. OIDO reviewed the facility RN training records and found that on June 15 and August 25, 2022, the Physician and Health Service Administrator (HSA) conducted CHA training for applicable RN staff.

The Facility Complied with Requirements to Monitor Detainees with Chronic Conditions

The 2011 PBNDS section 4.3 on medical care requires that detainees with chronic conditions receive care and treatment as needed, which includes monitoring of medications, diagnostic testing, and chronic care clinics.

OIDO randomly selected and reviewed nine medical records for detainees with chronic care conditions. All were enrolled in the chronic care clinic, had medications and diagnostic services ordered as needed, were referred to other specialty care providers, and had follow-up appointments scheduled. Eight of the nine (89 percent) chronic care records reviewed were completed appropriately. OIDO noted one incident where health care staff did not follow the physician orders for blood pressure monitoring.

B. Areas of Non-Compliance

i. Custody Findings

The Facility Urgent Care Room Had a Mosquito Infestation and a Faulty Door Latch

The 2011 PBNDS section 1.2 on environmental health and safety requires that pests and vermin be controlled and eliminated. The Facility Administrator is required to contract with licensed pest-control professionals to perform monthly inspections to identify and eradicate rodents, insects, and other vermin. The contract shall provide a preventive spraying program for indigenous insects and a provision for callback services as necessary. Doors to the outside should be tight-fitting, and door sweeps should be installed to prevent the entry of vermin from outside.

On October 26, 2022, during the inspection, OIDO found a mosquito infestation in the Urgent Care Room (*See* Exhibit 3). OIDO observed that the facility's Urgent Care door had an inoperable locking/latching mechanism, which prevented the door from closing properly. OIDO observed mosquitoes on walls, privacy screens, a stretcher, and other surfaces. OIDO alerted the HSA, Facility Administrator, and maintenance staff to both the unsecured door and the mosquito problem. At the conclusion of OIDO's inspection, a door repair had not been completed.

Exhibit 3. Urgent Care Room in medical clinic with mosquito on the wall (left); on a privacy screen (middle); and on wall and sharps container (right), as observed by OIDO on October 26, 2022.
Source: OIDO

In addition, the unsecured door opened to an inner perimeter walkway and could allow unauthorized access to emergency medical equipment and supplies (*See* Exhibit 4). Because the door was not secure, this also allowed the mosquito infestation to develop.

Exhibit 4. Urgent Care Room in medical clinic with inoperable door latch and access to outside area (top); emergency equipment in medical clinic (bottom left and right), as observed by OIDO on October 25, 2022.
Source: OIDO

The Facility Provided Detainees with Frequent Informal Access to ICE ERO Staff but Did Not Post the Visitation Schedule

The 2011 PBNDS section 2.13 on staff–detainee communication states that the facility shall not restrict detainees from having frequent informal access to and interaction with key facility and ICE ERO staff. The scheduled hours and days that ICE ERO staff are available to detainees must be posted in the living areas of the facility and updated at least quarterly. Further, it requires that the facility provide a secure drop box for ICE detainees to correspond directly with ICE management. Only ICE personnel shall have access to the drop box.

OIDO observed that current contact information for the ICE ERO Field Office was posted in the housing units and had been recently updated. However, the ICE ERO staff scheduled hours and days of availability were not posted as required. OIDO interviewed the ICE Deputy Field Office Director, who explained that ICE ERO kept three deportation officers detailed to the facility on 45-day rotations. OIDO reviewed ICE ERO visitation logs dated May 15 to October 25, 2022, and found that they documented ICE ERO visits on 101 of these 135 days.

OIDO reviewed the 2021 local supplement to the National Detainee Handbook, which explained how detainees could submit written questions, requests, or concerns to facility staff or ICE ERO

staff using the Detainee Request Form and placing such requests into a secure drop box in the cafeteria. OIDO observed drop boxes in the cafeteria labeled "Medical Request Grievances," "Request/Grievance," "I.C.E. Request," and "US Mail" (*See* Exhibit 5).

Exhibit 5. Secure drop boxes located in cafeteria at SLIPC, as observed by OIDO on October 25, 2022.
Source: OIDO

The facility and ICE ERO used an electronic logbook to track intake and response of detainee request forms. OIDO reviewed the electronic logbooks and found that the logbooks contained the required information. Further, OIDO found that ICE ERO responded within required time frames. ICE ERO has established an effective staff–detainee communication program that supports orderly facility operations. The program allows frequent informal contact with staff and detainees can submit requests and receive timely information regarding their immigration cases or matters within the facility, thus keeping the detainees informed. However, the ICE ERO visitation schedule must be posted and updated when rotational staffing changes are made.

The Facility's Control Relating to Firearms Issuance Did Not Comply with Requirements

SLIPC Policy No. 10.1.11, Control of Firearms and Other Security Equipment (Armory) requires that the facility maintain a written record of routine and emergency distribution of security equipment. Firearms, chemical agents, and related security equipment are inventoried at least monthly to determine their condition and expiration dates. The Facility Administrator will ensure systems are in place to document the issue, use, and return of all security equipment. GEO officers will receive training in the safe handling and use of approved security equipment. Contract security officers shall not be authorized to handle or carry firearms at any time.

OIDO reviewed 77 total line entries in the Armory Entry/Exit Logbook recorded between October 17 and 25, 2022. OIDO found that one entry was missing; specifically, the time when a firearm was checked out was not recorded. OIDO also reviewed entries in the Armory's Weapon Issuance Logbook for the period of October 13 to 25, 2022, and found that there were three incomplete entries. One entry was missing a signature for the individual who returned the firearm; one entry was missing signatures both for the individual who returned and the individual who received the firearm; and one entry did not have the time when a firearm was checked out. OIDO reviewed 23 entries in the Central Control Equipment Issue Logbook for the period dating from May 4 to October 17, 2022. OIDO found that security staff did not accurately complete the log as directed in the opening instruction guide of the logbook. Specifically, all entries must note a time and date. OIDO found that three of the 23 log entries were incomplete. Specifically, two entries, one for a video camera and another for an emergency key, did not include the date or time the equipment was returned.

Armory safety and supervision requires accurate documentation by the assigned supervisor(s) to safeguard, distribute, collect, maintain, and verify 100 percent accountability for weapons, munitions, equipment, chemicals, and related documentation. Proper documentation is essential for accountability to verify compliance with laws, standards, policies, and procedures and to avoid unsafe acts.

Facility Staff Failed to Post a Munitions Inventory List on the Armory Chemical Munitions Storage Cabinet or in the Armory

SLIPC Policy No. 10.1.11, Control of Firearms and Other Security Equipment (Armory), provides that armory staff will maintain running inventories on all supply items. Staff will post inventory sheets or cards in the immediate storage area of each item.

OIDO observed the armory chemical munitions storage cabinet and found that it did not have a munitions inventory list posted on the exterior or the interior of the cabinet. In addition, the facility did not have an inventory list posted in the Armory. OIDO observed that the inventory list was instead stored in the Armory Sergeant's office located inside the facility in the warehouse (*See* Exhibit 6).

Armory safety and supervision requires accurate documentation to safeguard, distribute, collect, maintain, and verify accountability for weapons, munitions, equipment, chemicals, and related documentation. Proper documentation is essential for accountability to verify compliance and to avoid unsafe acts.

Exhibit 6. Armory chemical munitions storage cabinet with doors closed (left) and doors open (right) showing that no inventory list was posted on or inside the cabinet, as observed by OIDO on October 27, 2022.
Source: OIDO

ii. Medical Findings

The Facility Health Care Staffing Did Not Meet the Shared Services Staffing Plan

The 2011 PBNDS section 4.3 on medical care requires that health care services are provided by a sufficient number of appropriately trained and qualified personnel with the appropriate state and/or

federal requirements. In addition, the facility is required to perform an annual review of its staffing plan to identify the positions needed to perform the required services.

SLIPC is under a shared services contract with its sister facility, PPIPC. In 2020, a modification to the IGSA incorporated a tiered staffing plan for both SLIPC and PPIPC. The SLIPC staffing plan contains two staffing provisions for ICE detainees: one for a guaranteed minimum of 700 beds, and one for 1,000 beds. OIDO reviewed both SLIPC staffing plans, which designated staffing requirements for both custody and health care staff. The 700-bed staffing plan required 24.17 full-time equivalent (FTE) health care staff, and the 1,000-bed staffing plan required 28.50 FTE health care staff. During OIDO's inspection, the detained population ranged from 625 to 759.

OIDO reviewed the SLIPC October 2022 health care staffing schedule[12] and health care vacancy list and found that the facility had seven vacant positions. Utilizing the designated staffing plan for a detained population of 701 to 1,000 detainees, SLIPC had a vacancy rate of approximately 25 percent, most notably in positions that performed oversight of health care services (i.e., HSA, clinical medical authority [physician], and director of nursing). The Regional Health Services Administrator (RHSA), who was the acting HSA for both SLIPC and PPIPC, reported that the facility augmented staff through surge resources and temporary duty personnel from Folkston ICE Processing Center and Annex in Georgia; however, this support was limited to nursing staff. In addition, the RHSA provided undated notes from a GEO central regional leadership meeting where vacancies and staffing issues were discussed on a national level. This document showed that some vacancies were open for greater than 90 days and that three of the seven vacant positions had potential employees who were in the hiring process.

A shared staffing plan provides the ability to support two sites that are located 30 to 45 minutes apart with the same staff, thus filling the FTE for both facilities with the same person. In response to an increase of a detained population of 701 to 1,000, the plan only augments staffing by increasing nursing positions. There is no additional coverage for advanced practice providers (APPs)[13] or health care professionals above the APPs. The 700-bed staffing plan and the 1,000-bed staffing plan show a variance of up to 300 detainees. However, the required number of APPs and health care professionals above the APPs does not change when the detainee population increases. Therefore, when the ICE detainee population increases, the current staffing provisions require the APPs and health care professionals above the APPs to use the same number of staff members, who must increase their workload and the services provided. In turn, this could limit detainee access to a higher level of care, when clinically indicated.

The Facility Health Care Credential Files Were Not Compliant with Requirements

The 2011 PBNDS section 4.3 on medical care requires health care personnel to perform duties within areas for which they are credentialed by training, licensure, certification, job descriptions, and/or other authorizations. All personnel must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. Copies of the documents must be maintained on site and readily available for review.

[12] OIDO requested but did not receive a copy of the facility's on-call schedule for October 2022.
[13] Advanced practice providers are health care professionals who are not physicians but have specialized education, training, and certification to provide services like medical diagnosis and treatment. They include physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives. APPs in the detention setting are either physician assistants or nurse practitioners.

OIDO reviewed 11 credential files and 100 percent were incomplete, contained expired documents, and/or lacked organization. Although the RHSA stated that GEO job descriptions are proprietary and should not be audited, OIDO notes that the standards require that health care personnel perform duties for which they are credentialed, including by job description. In addition, GEO Policy No. 402-A, Credentialing and License Verification, requires that the credentialing file will contain a job description.

GEO uses a credentials management system located at the headquarters level. A facility HSA is then required to obtain copies of documents when they are available for APPs and health care positions above the APPs. Because the RHSA was not fully knowledgeable about the credentialing policies, files were improperly maintained on-site and were not readily available. Without evidence of current health care credentialing validated by primary source verification, OIDO was unable to determine if the care that is being provided at SLIPC met state or federal requirements. This increases the risk of a negative care outcomes.

The Facility's Emergency Response Plan and Emergency Training Did Not Meet Requirements

The 2011 PBNDS section 7.3 on staff training requires personnel and contractors assigned to any type of emergency response unit or team to receive initial and annual training commensurate with these responsibilities, including annual refresher courses on emergency procedures and protocols. In addition, the 2011 PBNDS section 4.3 on medical care requires that detention and health care personnel be trained initially and annually on the proper use of emergency medical equipment and response to health-related emergency situations. The facility administrator must ensure that nonmedical staff have appropriate training and competency to implement the facility's emergency plan, to include recognizing signs of potential health emergencies and their required responses as well as signs and symptoms of mental illness and suicide risk.

The 2011 PBNDS section 4.3 on medical care also requires detention and health care personnel to be trained annually to respond to health-related situations within four minutes and on security procedures that ensure the immediate transfer of detainees for emergency medical care. Moreover, GEO Local Operating Procedures (LOPs) No. 608-B, Emergency Services, outlines the procedures for health care staff to follow in the event of a medical emergency, including instructions for the emergent transport of detainees for emergency and hospital services. Finally, SLIPC holds a National Commission on Correctional Health Care (NCCHC) accreditation and is therefore subject to NCCHC 2018 Standards for Health Services, Emergency Services and Response Plan, which requires facilities to conduct drills in preparation for emergency preparedness such as mass disaster drills.[14] These must be conducted on a schedule such that each shift participates over a three-year period, including satellites. Health emergency man-down drills should be practiced once a year on each shift, where health care personnel are regularly assigned. Mass disaster and man-down drills should be critiqued, the results shared with all health care personnel, and recommendations acted upon to improve response outcome.

OIDO reviewed five drill logs maintained in the four-minute drill binder and compared it to GEO LOP No. 608-B, Emergency Services. All five drill logs were missing information, such as time of response, equipment used, area of emergency, and name of responders. Four of the five drills

[14] Emergency Response Plan - National Commission on Correctional Health Care (ncchc.org): J-D-07 Emergency Services and Response Plan requires that health staff are prepared to implement the health aspects of the facility's emergency response plan. To comply with this standard, health staff must first have a written plan in place.

reviewed provided limited training opportunities and had minimal staff participation. For instance, one drill reviewed had only one health care staff and one correctional staff representative. The drills reviewed did not record use of additional equipment, simulated emergency medical service notification, and/or medical care provided. Furthermore, the facility did not have records of annual mass disaster drills for 2020 or 2022.

OIDO then reviewed 18 employee records for annual emergency training. Of those records, only two employees completed all the required trainings; the remaining 16 employee records had missing emergency trainings, such as cardiopulmonary resuscitation (CPR), grievances, emergency plans, and/or suicide intervention.

Based on OIDO's review, the RHSA or designee did not appropriately maintain or monitor SLIPC's health care personnel's completion of emergency response drills and related training. Ineffective and poorly planned training for medical emergencies promotes negative care outcomes, the potential for significant harm, and does not provide the needed education to ensure quality and timely medical emergency response.

The Facility Did Not Properly Maintain Monitors for Negative Pressure Isolations Rooms

The 2011 PBNDS section 4.3 on medical care requires that the facility shall place detainees with symptoms suggestive of tuberculosis, or with suspected or confirmed active tuberculosis disease based upon clinical or laboratory findings, in a functional airborne isolation room with negative-pressure ventilation.

OIDO observed the facility had three negative pressure isolation rooms available for use. For these rooms, a functioning monitor displays in green, but here the monitor display was gray. OIDO found the monitor for Isolation Room 137, which was occupied by a detainee on respiratory isolation, was not functioning properly, because the display read "SUICIDE VEST" (the detainee was not suicidal) and "TO BE CLEANED" (*See* Exhibit 7). OIDO reported this finding to the RHSA and maintenance during its inspection.

Exhibit 7. Medical Isolation Room 137 monitor (left); outside hallway view of Medical Isolation Room 137 with poster showing type of precautions for patient housed within and room monitor on right side (right), as observed by OIDO on October 25, 2022.
Source: OIDO

Based on interviews with the RHSA, maintenance supervisor, and nursing staff, there was a disconnect between medical staff and maintenance concerning how the system functions, who is responsible for monitoring negative pressure rooms and the frequency of that monitoring. Negative-pressure rooms that are not functioning or malfunctioning could lead to the spread of communicable disease in the facility and in the community.

The Facility Did Not Routinely Check Emergency Equipment and First Aid Kits

The 2011 PBNDS section 4.3 on medical care requires that medical and safety equipment be available and maintained. According to the GEO Policy No. 1001-A, Automatic External Defibrillator (AED), the HSA/designee is responsible for ensuring that all facility AEDs are checked daily using Defibrillator (AED) Daily Monitoring Form HS-219 and ensuring they are functioning properly and the batteries are charged. OIDO reviewed the daily AED equipment check logs for October 2022 and found 20 missing entries for the month.

GEO Policy No. 1004-A, Emergency Medications and First Aid Kits, specifies the minimum number of supplies necessary to handle minor emergencies and places responsibility of maintaining the first aid kits on the HSA. The policy further requires that each first aid kit will be checked for completeness not less than monthly by the HSA or a designee using First Aid Kit Monthly Checklist Form HS-240 and that the HSA/designee should maintain such records. OIDO reviewed first aid kit monthly checklist logs and found missing entries and supplies. OIDO could not find a completed checklist for the first aid kit/emergency bag.

The RHSA stated that no first aid kits were available at SLIPC; the RHSA also noted that there were only two emergency bags, and both were in the Urgent Care Room. At the time of OIDO's inspection, the HSA was not conducting random checks to ensure that medical staff were completing their daily and monthly checks of the equipment.

Nonfunctional or missing emergency equipment could lead to negative care outcomes during an emergency medical response. Prior to the conclusion of OIDO's inspection, the RHSA reported he placed a checklist and log into the Urgent Care Room for emergency equipment checks.

The Facility Did Not Conduct Timely Mental Health Assessments or Complete Health Care Documentation

The 2011 PBNDS section 4.3 requires that any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary.

OIDO randomly selected and reviewed 20 mental health records dated from July to October 2022. Eleven charts were selected from the psychotropic medication pharmacy list, and nine charts were selected from the suicide watch logbooks. OIDO found that 14 out of 20 charts reviewed (70 percent) were incomplete, as they were missing a mental health encounter and follow-up notes. In addition, two mental health records did not have signed consent forms. Further, OIDO found that there were delays in mental health assessments that spanned from five days to one month.

At the time of OIDO's inspection, SLIPC had one psychologist providing telehealth mental health services. During the review of medical records, OIDO found that the mental health provider was on medical leave, thus unavailable. During that psychologist's medical leave, the RHSA did not schedule a substitute mental health provider, nor did an APP or health care professional above an

APP provide services for mental health referrals. Per the RHSA, the contractor hired a licensed clinical social worker (LCSW). However, at the time of inspection, the facility did not have a start date for the social worker. A lack of adequate mental health coverage can lead to untimely access to mental health care thus increasing the risk of negative care outcomes.

The Facility Did Not Protect Detainees' Personal Health Information During Telehealth Sessions

The 2011 PBNDS section 4.3 on medical care requires that all medical providers, detention officers, and staff shall protect the privacy of detainees' medical information in accordance with established guidelines and applicable laws. In addition, GEO's Policy No. 627, Medical and Mental Health Services, Telehealth, requires that, for detainees who receive telehealth appointments, "[c]orrectional officer(s) will be available nearby, but not in the same room" as the detainee during telehealth appointments "to provide security in the same manner as any other medical appointment." Facility staff must maintain detainee privacy.

OIDO observed several in-progress telehealth sessions during this inspection. OIDO observed a custody officer sitting in the same room with a detainee during an active telehealth session; this arrangement did not allow for a reasonable degree of privacy (*See* Exhibit 8).

Exhibit 8. Security officer seated in room while detainee telehealth appointment in progress, as observed by OIDO on October 26, 2022.
Source: OIDO

OIDO observed that a patient appointment list was also left in plain sight for other detainees to read in the telehealth office, violating privacy standards (*See* Exhibit 9). The facility did not follow established protocols for managing and safeguarding confidential medical information. Safety and confidentiality are priorities in immigration detention settings. Failure to maintain privacy during health sessions can result in unauthorized disclosure of information.

Exhibit 9. List of detainees (redacted) with telehealth mental health appointments scheduled for October 25, 2022, on desk in telehealth appointment room (left); telehealth appointment room setup for detainees with desk, chair, and monitor (right), as observed by OIDO on October 25, 2022.
Source: OIDO

The Facility Did Not Complete Initial Intake Screenings Within 12 Hours

The 2011 PBNDS section 4.3 on medical care requires that all detainees receive an initial medical, dental, and mental health screening and be asked for information regarding any known acute or emergent medical conditions by a health care provider or a specially trained detention officer no later than 12 hours after arrival.

OIDO interviewed an RN who advised that 78 intake screenings from two days prior were still outstanding. OIDO randomly selected and reviewed 13 intake screenings and found that only seven of 13 records reviewed indicated that intake screenings were completed within 12 hours (54 percent). The RN reported that the delays in intake screening completion were due to a lack of health care staff. As noted, at the time of OIDO's inspection, the facility had a vacancy rate in health care staffing of 25 percent, notably among positions that perform oversight. OIDO notes as well that the facility received a large influx of detainees from another facility during the week of its inspection.

Delays in completing detainee intake screenings could result in detainees missing essential medications for extended periods of time or detainees not being timely identified with chronic or acute conditions, which could result in delayed referrals. These delays could lead to negative care outcomes.

The Facility Did Not Complete Comprehensive Health Assessments Within 14 Days of Arrival or Sooner as Clinically Indicated

The 2011 PBNDS section 4.3 on medical care requires facility health care providers to conduct a CHA, including a physical examination and mental health screening, with each detainee within 14 days of their arrival, unless more immediate attention is required due to an acute or identifiable chronic condition. When a clinically significant finding is noted during the intake screening, health care staff are required to initiate an immediate referral for a CHA to be conducted no later than two working days after the initial screening.

OIDO randomly selected and reviewed 12 detainee medical records dated from July to October 2022 for completion of the CHA. Among the 12 records reviewed, OIDO found that five detainees

had a clinically significant finding that required an immediate referral and a CHA completed within two working days. However, OIDO found all five detainees did not receive a CHA appointment within two working days. CHA completion times ranged from three days to 26 days.

Further, among the other seven remaining records reviewed, OIDO found that these detainees did not have clinically significant findings during the intake screening and, therefore, required a CHA to be completed within 14 days of arrival. Of the seven records, five (71 percent) of these detainees had CHAs outside the 14-day period. Specifically, four detainees received CHAs in 22 days, and one detainee had no record of receiving a CHA.

SLIPC's 25 percent health staff vacancy rate was likely a contributing factor to the untimely completion of CHAs. In addition, the increased detainee influx that the facility received within the two days prior to OIDO's inspection likely compromised the ability of staff to timely complete the CHAs. Timely completion of CHAs in the immigration detention setting is vital to ensure detainees receive appropriate access to care.

The Facility Did Not Provide Timely Responses to Sick Call Requests

The 2011 PBNDS section 4.3 on medical care requires all facilities to have an established procedure in place to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee's medical record. Medical personnel shall review the request slips and determine when the detainee will be seen based on acuity of the problem. In an urgent situation, the housing unit officer must notify medical personnel immediately.

Interviews with health care staff revealed that health care staff were not following the procedures to process detainees' health service requests that are outlined in GEO Policy No. 625, Sick Call and Triaging of Non-Emergent Requests for Health Services, and SLIPC LOPs No. 625-B and 625-C, Sick Call and Triaging of Non-Emergent Requests for Health Services. Specifically, OIDO notes that staff were not appropriately logging sick call requests that staff received. OIDO found additional knowledge area deficits regarding electronic tablet system documentation, nursing assessment protocols and documentation requirements, and requirements for verbal orders that staff received.

OIDO randomly selected and reviewed nine sick call requests from the facility's sick call request log with received dates between January 1, 2021, and October 24, 2022. Six of the nine sick call requests reviewed were submitted through an electronic tablet. Only five of the nine (56 percent) sick call requests were triaged within 24 hours as the standard requires. In addition, three of the nine sick call requests lacked appropriate nursing assessment and documentation in the medical record. For instance, two medical records lacked co-signatures from an APP or physician for prescription medication given, and one chart lacked an appropriate nursing assessment and documentation. Delays in or incorrect completion of sick call requests could prevent detainees from receiving timely access to health care thus increasing the risk for negative care outcomes.

The Facility Detainee Handbook Had Not Been Updated to Include Instructions for Requesting Health Care Services Using the Electronic Tablet

The 2011 PBNDS section 4.3 on medical care requires the facility to provide each detainee, upon admittance, a copy of the detainee handbook and local supplement, which contains procedures for

requesting and accessing health care services. OIDO reviewed the 2022 SLIPC Revised Supplement to the National Detainee Handbook. For medical requests, the handbook advised detainees to complete a medical request form and to place the sick call form in the box labeled "Medical Requests" located in the main hallway in the housing unit or to submit an electronic medical request. However, the local supplement had not been updated to include procedures or instructions for detainees to submit sick call requests through the electronic tablets.

The Facility Did Not Provide Timely Mental Health Evaluations When Females Reported a History of Abuse or Violence

The 2011 PBNDS section 4.4 on medical care (women) requires that if the initial detainee medical intake screening indicates any history of domestic abuse or violence, the detainee shall be referred for and receive a mental health evaluation by a qualified mental health provider within 72 hours, or sooner if appropriate, consistent with the 2011 PBNDS section 4.3 on medical care.

OIDO randomly selected and reviewed 13 intake screenings dating from July 1 to October 2022 and found 11 out of the 13 medical records reviewed indicated a positive history of domestic abuse or violence, warranting a 72-hour referral to a mental health provider. Two out of the 11 medical records that warranted a 72-hour referral based on intake screening revealed mental health referrals were initiated; however, the detainees were by a mental health provider within 72 hours. The two detainees were seen 11 and 25 days, respectively, after the referrals were initiated. The detainee seen after 11 days was eventually seen via a telepsychiatry appointment. The detainee seen after 25 days was seen after the mental health provider returned from a leave of absence.

The facility failed to implement a staffing plan that ensured continuous coverage of essential mental health services. At the time of OIDO's inspection, the facility had one psychologist assigned to provide telehealth mental health services, who was on medical leave and thus unavailable. The facility did not schedule a replacement during the psychologist's absence, which resulted in no mental health services being available during that time. As the RHSA advised, an LCSW had been hired; however, the facility had no projected start date. The inability to provide adequate mental health services denies access to care for victims of domestic abuse.

The Facility Did Not Consistently Document Pregnancy Testing Results for New Arrivals

The PBNDS 2011 section 4.4 on medical care (women) provides that pregnant detainees shall have access to pregnancy services, including pregnancy testing. If the initial medical intake screening indicates the possibility of pregnancy, referral shall be initiated, and the detainee shall receive a health assessment as soon as appropriate or within two working days.

OIDO randomly selected and reviewed 11 intake screenings to determine compliance with pregnancy testing. The facility provided urine pregnancy test results taken during intake screenings. Of the 11 intake screenings reviewed, eight had completed pregnancy tests. The other three intake screenings did not contain documentation regarding pregnancy testing. This failure to document testing results can lead to a failure in identifying pregnant female detainees, which could result in a delay in receiving necessary prenatal care and could lead to negative health care outcomes.

The Facility Did Not Provide Privacy to Detainees to Perform Bodily Functions in the Mental Health Unit's Suicide-Watch Cell

The 2011 PBNDS section 4.5 on personal hygiene requires that detainees be provided with a reasonably private environment in accordance with safety and security needs. OIDO observed placement of security cameras and Medical Control Booth monitoring of suicide-watch cells. OIDO noted that two security cameras in the largest suicide-watch cell were directed toward the toilet. One security camera pointed directly at the toilet, preventing detainees from having a reasonably private environment (*See* Exhibit 10).

Exhibit 10. Security camera pointed at toilet in suicide-watch cell, as observed by OIDO on October 25, 2022.
Source: OIDO

The Facility Did Not Properly Monitor and Document Records for Detainees on Suicide Watch

The 2011 PBNDS section 4.6 on significant self-harm and suicide prevention and intervention requires that a suicidal detainee receive close supervision in a setting that minimizes opportunities for self-harm. If a staff member identifies someone who is at risk of significant self-harm or suicide, the detainee must be placed on suicide precautions and immediately referred to a qualified mental health professional. The qualified mental health professional may place the detainee in a special isolation room designed for evaluation and treatment with continuous monitoring that must be documented every 15 minutes, or more frequently if necessary.

OIDO reviewed GEO Policy 907/907-A, Suicide Prevention and Intervention, and found a discrepancy between the policy and the 2011 PBNDS. The 2011 PBNDS section 4.6 on significant self-harm and suicide prevention and intervention provides that "[a]ll detainees discharged from suicide observation should be reassessed within 72 hours and then periodically at intervals prescribed by the treatment plan and consistent with the level of acuity by an appropriately trained and qualified medical staff member." GEO Policy 907/907-A requires that, "[a]t the minimum, follow-up assessment will occur within seven days from the time of discharge, or sooner if clinically indicated or if required by the client."

OIDO observed a detainee who was in medical isolation in the infirmary due to a psychological condition, according to the HSA. OIDO reviewed the medical record, but the reason for isolation was not clear or properly documented. OIDO also observed that the custody officer on the observation/watch had no logbook in which to enter any pertinent information regarding the detainee's condition.

OIDO also reviewed all 11 charts from the psychotropic medication pharmacy list from July to October 2022, as well as eight suicide-watch logs. OIDO found that 67 percent of the charts and watch logs reviewed were incomplete and/or missing follow up care. Because the facility did not follow established protocols and procedures related to monitoring and documenting detainees on suicide watch, these failures could both jeopardize efforts to improve suicide prevention and intervention and negatively affect care outcomes.

The Facility Did Not Log Medical Grievances Accurately or Resolve Them in a Timely Manner

For medical grievances, the 2011 PBNDS section 6.2 on grievance system provides that each facility shall have written policy and procedures for a detainee grievance system that ensures a procedure in which all medical grievances are received by the administrative health authority within 24 hours or the next business day, with a response from medical staff within five working days, where practicable. The facility grievance system should also establish a special procedure for time-sensitive, emergency grievances, including having a mechanism by which emergency medical grievances are screened as soon as practicable by appropriate personnel.

OIDO reviewed SLIPC Policy No. 9.1.3, Detainee Grievance Procedure, as well as LOP No. 205-B, Grievances, and found that that both established procedures for medical grievance receipt and review. SLIPC Policy No. 9.1.3 included a special procedure for the handling of time-sensitive emergency grievances. However, OIDO reviewed records for medical grievances and found that they had not been documented or resolved according to these procedures. Specifically, the RHSA stated that the medical unit is in the process of automating medical grievances to an electronic logbook. OIDO reviewed a written medical grievance binder that contained five detainee grievance forms and compared it to a printout from the electronic medical grievance log. OIDO found that the assigned grievance numbers were not consistent or in chronological order. One medical grievance did not reflect that it had been resolved within five days.

While the facility had a written procedure that detailed how to create and document grievances, the staff was not consistently using that procedure to document, track, and respond to grievances. Without adhering to an effective grievance tracking system, grievances could go unresolved.

The Facility Did Not Consistently Perform COVID-19 Testing at Intake or Have Documentation Showing COVID-19 Testing Was Completed Prior to Release or Transfer

The ICE ERO COVID-19 PRR states that each facility will, on a weekly basis, determine its COVID-19 operational status based on the Centers for Disease Control and Prevention's (CDC) Guidance on Prevention and Management of Coronavirus Disease 2019 in Correctional and Detention Facilities released on May 3, 2022.[15] Facilities must use four measures that, in combination, will assign a specific response level to the facility. Once the values are determined, the facility will follow the PRR decision matrix to determine the facility status for the week: green, yellow, or red.

During OIDO's inspection, SLIPC was operating under yellow status. For this status, the PRR requires, among other things, that all detainees, staff, and other persons in the facility receive a COVID-19 symptom screening and temperature check, wear a well-fitting mask while indoors,

[15] OIDO used the ICE ERO PRR Version 9.0, dated June 13, 2022, to conduct its inspection: ERO COVID19 Pandemic Response Requirements Version 9 June 13, 2022.pdf. The CDC guidance is available here: CDC Guidance on Prevention and Management of Coronavirus Disease 2019.

test all detainees upon intake regardless of vaccination status, medically isolate detainees who test positive for COVID-19 and quarantine their close contacts, and maintain isolation of COVID-19-positive detainees until all CDC release criteria have been met. The facility is also required to offer all ICE detainees the COVID-19 vaccine in accordance with state priorities and guidance.

OIDO noted that the facility did not consistently conduct verbal symptom screening for visitors and staff entering the facility. The facility conducted daily temperature checks for those entering the facility on all three days of the OIDO inspection; however, the facility conducted the daily symptom screening only on the first day. In addition, OIDO observed that the facility's security, medical staff, and detainees did not consistently wear face masks in the facility. OIDO also observed that no facility employees asked any staff, detainees, or OIDO inspectors to wear a face mask. In the medical care areas, OIDO observed that health care staff did not consistently wear required personal protective equipment (PPE) or correctly wear PPE while performing work.

OIDO reviewed 11 medical records and found that nine of the 11 records (82 percent) reflected that the detainee refused COVID-19 testing at intake.[16] OIDO found that the ICE ERO PRR Version 9 (June 13, 2022) did not provide guidance regarding detainees who refused COVID-19 testing during intake.[17] In addition, one of the 11 records did not contain evidence that the detainee had been screened for COVID-19 symptoms during intake; the detainee's form included only the detainee's name, demographic information, and signature. Further, two of the 11 (18 percent) medical records did not have any documentation regarding the detainee's vaccination status. Finally, OIDO found that one detainee housed in the medical housing unit at the time of OIDO's inspection was positive for COVID-19. However, there was no documentation in the detainee's medical record that the nursing staff were routinely monitoring the detainee's symptoms.

At the time of OIDO's inspection, testing for COVID-19, in addition to symptom screening, was required to adequately maintain and control the spread of COVID-19. In addition, at the time of the inspection, the facility was to adhere to both the ICE ERO PRR and CDC guidance. Failure to accurately document the implementation of COVID-19 protocols, puts the detained population at risk. Although OIDO recognizes the May 11, 2023, expiration of the CDC's temporary public health order under Title 42 of the Public Health Services Act[18] the facility should continue to adhere to ICE ERO's most recent post-pandemic guidance.[19]

Conclusion

OIDO's inspection led to several findings. SLIPC complied with specific standards in 14 areas reviewed. In addition, the facility had 21 instances of non-compliance with standards and/or contract terms. OIDO made seven recommendations designed to improve operations at the facility and meet ICE detention standards and contract terms.

[16] OIDO received a new arrival roster for the October 10 and 11, 2022, from which OIDO randomly picked the fifth name on the list, and then included every additional tenth detainee on the list that followed until reaching 11 charts.
[17] OIDO used the ICE ERO PRR Version 9.0, dated June 13, 2022, to conduct its inspection. *See* ERO COVID-19 Pandemic Response Requirements Version 9 June 13, 2022.pdf.
[18] Title 42 of the Public Health Services Act is a public health authority that authorizes the Director of the Centers for Disease Control and Prevention (CDC) to suspend entry of individuals into the U.S. to protect public health.
[19] *See* Post Emergency COVID-19 Guidelines and Protocol.

It is essential that SLIPC comply with the 2011 PBNDS and contract terms to ensure the health, safety, and rights of detainees. ICE must ensure that SLIPC complies with both the detention standards and the contract terms and takes meaningful action to address these deficiencies.

It is also important to comply with government procurement regulations as they relate to contract assurance to ensure that performance services conform to contract requirements.[20] Adherence is critical in but should not be limited to the assessment of current and discouragement of future nonconforming services.[21]

Recommendations

Recommendation 1: For contract compliance, conduct a thorough review of the current IGSA and all modifications to ensure the Shared Services Staffing Plan between PPIPC and SLIPC complies with contractual staffing requirements to support proper supervision, efficient management of detention operations, and timely access to necessary health care for detainees at both facilities.

Recommendation 2: For safety and security of the facility and detainee well-being, fix the inoperable locking and latching mechanisms on the exterior door to the Urgent Care Room and take steps to eradicate any mosquito infestation and prevent reoccurrence.

Recommendation 3: To improve staff–detainee communication, take steps to ensure ICE ERO staff visitation schedules are accurate and posted throughout housing units and common areas as required.

Recommendation 4: For control of firearms and other security equipment, implement internal controls that ensure documentation related to the issuance of firearms is 100 percent accurate and complete.

Recommendation 5: For control of firearms and other security equipment (armory), implement internal controls that ensure accurate inventories are maintained and inventory sheets or cards are in the immediate area of those items.

Recommendation 6: Regarding medical care, ICE should consider suitable sanctions or penalties until such time that the stipulated contractual requirements listed below are fully met.

a) Facility health services are staffed in accordance with the Shared Services Staffing Plan.

b) Facility health services maintain complete, current, and readily available credentialing documentation for health care personnel.

c) Facility health services, in coordination with facility maintenance, repair negative-pressure isolation room monitors.

d) Facility health services maintain emergency equipment and check supplies daily and monthly, as applicable.

[20] *See* Federal Acquisition Regulation (FAR) Subpart 46.4, Government Contract Quality Assurance.
[21] *See* FAR 46.407, Nonconforming Supplies or Services.

e) Facility health services conduct initial intake screenings within 12 hours of a detainee's arrival.

f) Facility health services conduct comprehensive health assessments within 14 days of arrival, or sooner if clinically indicated.

g) Facility health services provide timely responses to sick call requests.

h) Facility health services conduct timely mental health assessments and complete the required documentation.

i) Facility health services maintain detainees' privacy and protect personal health information during telehealth sessions.

j) Facility health services, in coordination with facility administration, update the facility local handbook to include instructions for detainees to request health care services using the electronic tablet.

k) Facility health services provide timely mental health evaluations when females report a history of abuse or violence.

l) Facility health services document pregnancy testing results for all new female arrivals when applicable (i.e., women between the ages of 18 and 56 years old).

m) Facility health services, in coordination with facility administration, review security camera placement in the Mental Health Unit's suicide watch cell to provide detainees with a reasonable degree of privacy when performing bodily functions.

n) Facility health care personnel document reasons for placement, discharge, and follow-up care in electronic or written records for detainees on suicide watch.

o) Facility health services log and provide timely responses to medical grievances.

Recommendation 7: Implement procedures that ensure all required Emergency Response Plan and Emergency Training is provided and documented and that routine drills are conducted and documented.

Response from Inspected Component and OIDO Analysis

ICE officials concurred with all seven recommendations and identified corrective actions. Based on information in ICE's response to the draft report, OIDO considers Recommendation 1 unaddressed and open, Recommendations 6(a) and 7 addressed and open, and the other recommendations addressed and closed. While OIDO considers several recommendations closed due to ICE's responsive corrective actions, it notes that many of the non-compliance findings affect critical aspects of detainee safety; therefore, OIDO will continue to monitor these areas to ensure the deficiencies are not repeated. Below is a summary of ICE's response and OIDO's analysis thereof. The full response is available in Appendix A.

Component Response to Recommendation 1: Regarding contract compliance, ICE concurred with OIDO's recommendation. ICE indicated the ERO New Orleans Field Office monitors and manages the population and operations. In addition, ERO is currently exploring restructuring of the staffing plan and will adjust if warranted.

OIDO Analysis: OIDO finds these actions to be non-responsive to the recommendation and considers this matter unaddressed and open. OIDO will close this recommendation when ICE provides the results of its staffing plan restructuring exploration if the plan includes supporting proper supervision, efficient management of detention operations, and timely access to necessary health care for detainees at both facilities.

Component Response to Recommendation 2: Regarding safety and security, ICE concurred with OIDO's recommendation. ICE indicated GEO, the owner and operator of the facility, contacted a pest control company in October 2023 and has continued monthly pest control services since then. In addition, GEO maintenance evaluated the exterior door to the Urgent Care Room and found the mechanism to be functioning properly. However, it was discovered staff had been improperly propping the door open. GEO staff have added an emergency entrance sign on the door and dedicated its use to emergencies.

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

Component Response to Recommendation 3: Regarding staff–detainee communication, ICE concurred with OIDO's recommendation. ICE indicated ERO management ensured updated staff detained noncitizen visitation schedules are posted in all dorms, the law library, cafeteria, recreation areas, and other areas where detainees congregate. ICE has conducted weekly inspections to ensure compliance.

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

Component Response to Recommendation 4: Regarding control of firearms and security equipment, ICE concurred with OIDO's recommendation. ICE indicated GEO conducted a complete inventory of the armory in October 2022 and determined the inventory was correct. GEO conducted training with staff on the procedures for armory entries in January 2023.

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

Component Response to Recommendation 5: Regarding control of firearms and security equipment (armory), ICE concurred with OIDO's recommendation. ICE indicated the Chief of Security conducted a chemical munitions inventory and posted inventory sheets on the munition's cabinet in October 2022.

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

Component Response to Recommendation 6: Regarding medical care, ICE concurred with OIDO's recommendations. ICE ERO confirmed GEO has taken appropriate action to resolve identified deficiencies and will continue to monitor GEO's compliance with detention standards and employ contract remedies as appropriate should additional areas of non-compliance occur.

For Recommendation (a), ICE indicated GEO's audit noted seven vacant positions that were part of the shared staffing plan, while the facility utilized additional temporary-duty staff from other GEO facilities. After the inspection, GEO hired a Director of Nursing and four Licensed Practical Nurses, with two agreement nurses permanently assigned to SLIPC. ICE anticipates the end of the

shared staffing plan with PPIPC upon receiving the fiscal year (FY) 2024 budget.

OIDO Analysis: OIDO finds this recommendation partially responsive and considers this matter addressed and open. OIDO will close this recommendation when ICE provides supporting documentation to demonstrate that the shared staffing plan with PPIPC was terminated.

For Recommendation (b), ICE indicated immediate corrective action took place for all health services credentialing files. The HSA maintains a credentialing roster and periodically cross references this roster with paper files to ensure compliance, in addition to quarterly reviews.

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

For Recommendation (c), ICE indicated GEO's maintenance staff unlocked the control panel and switched the mode from "TO BE CLEANED" to "NEGATIVE PRESSURE." No further incidents of locked-out monitors have occurred.

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

For Recommendation (d), ICE indicated that first aid kits were not required, and supplies did not need monitoring because the facility maintains 24/7 medical coverage.

OIDO Analysis: OIDO acknowledges ICE's response and considers this matter closed. However, OIDO notes that because ICE and the Facility Administrator agree to not have first aid kits located throughout the facility, health care staff will have to respond to all incidents, even those of a non-urgent nature, potentially overburdening a less-than-ideal shared services staffing model.

For Recommendation (e), ICE indicated the HSA provided refresher training to all medical staff on completing initial intake screenings within 12 hours. The HSA or designee monitors records of 10 new arrivals weekly to ensure compliance.

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

For Recommendation (f), ICE indicated the HSA provided refresher training on comprehensive health assessments (CHAs). The Director of Nursing reviews the Sapphire electronic health record (eHR) intake processing queue daily to assess timeliness and ensure compliance.

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

For Recommendation (g), ICE indicated the HSA conducted refresher training to all medical staff regarding sick call requests via paper and electronic tablets. The Director of Nursing reviews requests to verify timely responses are given.

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

For Recommendation (h), ICE indicated the facility transitioned to the Sapphire eHR. Telehealth providers have direct access to Sapphire and can complete and submit the required documentation into detainee records.

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

For Recommendation (i), ICE indicated the Facility Administrator issued a directive to security staff specifying that staff should be directly outside the room to observe the session through the window during telehealth visits. Post orders were revised to include the new directive.

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

For Recommendation (j), ICE indicated the facility's local detainee handbook was revised to include procedures for making sick call requests using electronic tablets for improved privacy and protection of detainee health information. A memorandum was posted on every housing unit's bulletin board, and SLIPC utilizes paper request slips that can be placed in the mailboxes of each dorm in the event of trouble using a tablet.

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

For Recommendation (k), ICE indicated that Sapphire eHR automatically generates a mental referral when health care staff select "Yes" on questions about domestic violence or abuse. The HSA provided refresher training to staff on providing mental health referrals within 72 hours when a female detainee reports domestic abuse or violence.

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

For Recommendation (l), ICE indicated that Sapphire eHR eliminated the need for most paper documentation. The medical staff utilizes the system to enter results within 12 hours of a detainee's arrival to indicate a urine pregnancy test was completed. Medical staff conducting the detainee's medical history and physical will review each chart for completeness.

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

For Recommendation (m), ICE indicated the security cameras monitoring suicide-watch cells were repositioned to provide privacy for detainees when performing bodily functions.

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

For Recommendation (n), ICE indicated the HSA provided refresher training to the medical staff and providers on documenting the reason for suicide-watch placement, discharge, and follow-up care for detainees. To ensure compliance, a nurse was assigned to review 10 randomly selected medical charts a week.

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

For Recommendation (o), ICE indicated the HSA completed and reviewed all medical grievances to verify they were recorded in the medical grievance log. The HSA will continue this review to ensure compliance is maintained, and a compliance auditor began conducting weekly reviews to ensure grievances are logged and responded to within the required five-day time frame.

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

Component Response to Recommendation 7: Regarding emergency response plan and training, ICE concurred with OIDO's recommendation. ICE indicated the facility initiated emergency drills in December 2023 and documented the results. In addition, the Fire Safety Manager will continue to schedule drills, provide training, and ensure proper documentation is maintained.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation; however, the referenced attachment in the ICE response does not document the results of the emergency drills. Therefore, OIDO considers this matter addressed and open. OIDO will close this recommendation when ICE provides documentation demonstrating implementation.

Appendix A: Component Response

Enforcement and Removal Operations

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

U.S. Immigration and Customs Enforcement

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

FROM: Daniel A. Bible
Executive Associate Director
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement

DANIEL A BIBLE
Digitally signed by DANIEL A BIBLE
Date: 2024.06.10 12:10:18 -04'00'

SUBJECT: Response to the Office of the Immigration Detention Ombudsman's South Louisiana ICE Processing Center Inspection Report (Case No. 22-001083)

Purpose

This memorandum is in response to the Department of Homeland Security's Office of the Immigration Detention Ombudsman's (OIDO) draft inspection report, *OIDO Inspection of South Louisiana ICE Processing Center*. The inspection was held at the South Louisiana U.S. Immigration and Customs Enforcement (ICE) Processing Center from October 25-27, 2022.

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 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 Response to OIDO Recommendations

Recommendation 1: For contract compliance, conduct a thorough review of the current IGSA and all modifications to ensure the Shared Services Staffing Plan between Pine Prairie ICE Processing Center (PPIPC) and South Louisiana ICE Processing Center (SLIPC) complies with contractual staffing requirements to support proper supervision, efficient management of detention operations, and timely access to necessary health care for detainees at both facilities.

Response: ICE concurs with this recommendation. The ERO New Orleans Field Office continuously monitors and manages the population and operations to ensure proper detained noncitizen care. ERO is currently exploring restructuring of the staffing plan and will adjust if warranted.

Recommendation 2: For safety and security of the facility and detainee well-being, fix the inoperable locking and latching mechanisms on the exterior door to the Urgent Care Room and take steps to eradicate any mosquito infestation and prevent reoccurrence.

Response: ICE concurs with this recommendation, the PPIPC/SLIPC are facilities that are owned and operated by the GEO Group (GEO). GEO staff contacted a pest control company on October 26, 2022, that provided same-day service, and GEO has continued monthly services. Service invoices are attached for reference. Please refer to Attachment 1.

GEO maintenance evaluated the exterior door to the Urgent Care Room and found the locking mechanism to be functioning properly. However, it was discovered that staff was improperly propping the door open – compromising security – and at the same time allowed mosquitos to enter. Since the inspection, GEO staff have added an emergency entrance sign on the door, and dedicated it's use for emergencies. Please refer to Attachment 2.

Recommendation 3: To improve staff-detainee communication, take steps to ensure ICE ERO staff visitation schedules are accurate and posted throughout housing units and common areas as required.

Response: ICE concurs with this recommendation. ERO management has ensured updated staff detained noncitizen visitation schedules are posted in all dorms, the law library, cafeteria and recreation areas or other areas where detainees congregate, to include a posting in the Special Management Unit (SMU) and medical, and weekly inspections have ensured compliance. Please refer to Attachment 17.

Recommendation 4: For control of firearms and other security equipment, implement internal controls that ensure documentation related to the issuance of firearms is 100 percent accurate and complete.

Response: ICE concurs with this recommendation. On October 31, 2022, GEO conducted a complete inventory of the armory and determined the armory inventory was correct. GEO conducted training to staff on the procedures for Armory entries on January 31, 2023. Please refer to Attachment 3.

Recommendation 5: For control of firearms and other security equipment (armory), implement internal controls that ensure accurate inventories are maintained and inventory sheets or cards are in the immediate area of those items.

Response: ICE concurs with this recommendation. On October 31, 2022, the Chief of Security conducted a chemical munitions inventory and posted inventory sheets on the munition's cabinet. Please refer to Attachment 18.

Recommendation 6: Regarding medical care, ICE should consider suitable sanctions or penalties until such time that the stipulated contractual requirements listed below are fully met.

a) Facility health services are staffed in accordance with the Shared Services Staffing Plan.

b) Facility health services maintain complete, current, and readily available credentialing documentation for health care personnel.

c) Facility health services, in coordination with facility maintenance, repair negative pressure isolation room monitors.

d) Facility health services maintain emergency equipment and check supplies daily and monthly, as applicable.

e) Facility health services conduct initial intake screenings within 12 hours of a detainee's arrival.

f) Facility health services conduct comprehensive health assessments within 14 days of arrival, or sooner if clinically indicated.

g) Facility health services provide timely responses to sick call requests.

h) Facility health services conduct timely mental health assessments and complete the required documentation.

i) Facility health services maintain detainees' privacy and protect personal health information during telehealth sessions.

j) Facility health services, in coordination with facility administration, update the facility local handbook to include instructions for detainees to request health care services using the electronic tablet.

k) Facility health services provide timely mental health evaluations when females report a history of abuse or violence.

l) Facility health services document pregnancy testing results for all new female arrivals when applicable (i.e., women between the ages of 18-56 years old).

m) Facility health services, in coordination with facility administration, review security camera placement in the Mental Health Unit's suicide watch cell to provide detainees with a reasonable degree of privacy when performing bodily functions.

n) Facility health care personnel document reasons for placement, discharge, and follow-up care in electronic or written records for detainees on suicide watch.

o) Facility health services log and provide timely responses to medical grievances.

Response: ICE concurs with this recommendation. ERO confirmed GEO has taken appropriate action to resolve identified deficiencies. ERO will continue to monitor GEO's compliance with ICE detention standards and employ contract remedies as appropriate should additional areas of non-compliance occur.

a) GEO noted during the audit that the seven vacant positions were part of the shared staffing plan. The facility was, and is, currently utilizing additional temporary-duty staff from other GEO facilities. Since the inspection, GEO has hired a Director of Nursing and four licensed practical nurses—two agreement nurses who are permanently assigned to the South Louisiana ICE Processing Center. ICE anticipates the shared staffing plan with Pine Prairie ICE Processing Center will end once ICE receives a Fiscal Year 2024 budget.

b) On October 31, 2022, all health services credentialing files were reviewed to determine which needed required correction and reorganization. Immediate corrective action was taken. The Health Service Administrator (HSA) maintains a credentialing roster and periodically cross references it with paper files to ensure compliance. In addition, a quarterly review is conducted by the HSA.

c) GEO maintenance staff unlocked the control panel and switched the mode from "to be cleaned" to "negative pressure." No further instances of locked-out monitors have occurred. Please refer to Attachments 4 and 5.

d) The facility has determined that, because they maintain 24/7 medical coverage, first-aid kits were not required, and supplies did not need monitoring.

e) On May 30, 2023, the HSA provided refresher training to all clinical staff on completing initial intake screenings within 12 hours. The HSA, or designee, began monitoring records of 10 new arrivals weekly to ensure compliance. Please refer to Attachments 6 and 9.

f) On February 9, 2023, the HSA provided refresher training on comprehensive health assessments. The Director of Nursing began daily reviews of the Sapphire intake processing queue to assess timelines. Continued reviews to ensure compliance will be conducted daily. Please refer to Attachment 10.

g) On February 27, 2023, the HSA conducted refresher training to all medical staff regarding sick call requests through paper or electronic tablets. The Director of Nursing began reviewing requests to verify timely responses were given. Please refer to Attachment 11.

h) On November 17, 2022, the facility transitioned to the Sapphire electronic health record (eHR) system. All Telehealth providers now have direct access to Sapphire and can complete the required documentation and submit the information into non-citizens' records.

i) At the conclusion of the inspection, the Facility Administrator issued a directive to security staff specifying that during Telehealth visits staff should be posted directly outside the room and observe the session through the window. Post orders were revised to include the new directive. Please refer to Attachments 7 and 8.

j) On June 2, 2023, the facility's local detained noncitizen handbook was revised to include procedures for making sick call requests using electronic tablets to better provide improved privacy and protection of detained noncitizen health information. A memorandum was posted on each housing unit's bulletin board. SLIPC utilizes paper request slips that can be placed in the mailboxes mounted in each dorm should a non-citizen experience trouble with a tablet. Please refer to Attachment 12.

k) On November 17, 2022, the facility began using the Sapphire eHR system, which automatically generates a mental referral when health care staff select an answer of "Yes" on questions about a history of domestic violence or abuse. On May 26, 2023, the HSA provided refresher training to staff on providing mental health referrals within 72 hours of when a female detained noncitizen reports a history of domestic abuse or violence. Please refer to Attachment 13.

l) On November 17, 2022, the facility began using the Sapphire eHR system which eliminated the need for most of the paper documentation. The medical staff now utilizes the system to enter results within 12 hours of a noncitizen's arrival at the facility to indicate a urine pregnancy test was completed. Effective November 17, 2022, the clinical staff member conducting the noncitizen's medical history and physical will review each chart for completeness. Please refer to Attachment 9.

m) On May 31, 2023, the security cameras that monitor suicide-watch cells were repositioned to provide a reasonable degree of privacy to detained noncitizens when performing bodily functions. Please refer to Attachment 14.

n) On May 26, 2023, the HSA provided refresher training to all medical staff and providers on documenting the reason for suicide-watch placement, discharge, and follow-up care for detained noncitizens placed on suicide watch. On July 1, 2023, a nurse was assigned the duty of reviewing 10 randomly selected medical charts of detained noncitizens a week for compliance. Please refer to Attachment 15.

o) On February 28, 2023, the HSA completed and reviewed all medical grievances to verify all grievances were recorded on the medical grievance log. The HSA will continue this review to ensure compliance is maintained. On March 1, 2023, the compliance auditor began conducting weekly reviews to ensure grievances are logged and responded to within the required 5-day timeframe. Please refer to Attachment 16.

Recommendation 7: Implement procedures that ensure all required Emergency Response Plan and Emergency Training is provided and documented and that routine drills are conducted and documented.

Response: ICE concurs with this recommendation. The facility initiated emergency drills in December 2023 and documented the results. The fire-safety manager will continue to schedule drills, provide training, and ensure proper documentation is maintained. Please refer to Attachment 6.

Attachments

- Attachment 1: GEO Monthly Invoices
- Attachment 2: Photo of "Emergency Entrance Only" Sign
- Attachment 3: Training Verification
- Attachment 4: Daily Log of Checks Conducted (negative pressure room)
- Attachment 5: Test and Balance Report
- Attachment 6: AED Training (emergency response), May 2023 nursing In- Service
- Attachment 7: Photo of Directive Sign (telehealth)
- Attachment 8: Post Order (health Services Officer)
- Attachment 9: Intake Screening Training Verification
- Attachment 10: History & Physical (H&P Training verification
- Attachment 11: Sick Call Training Verification
- Attachment 12: Detainee Handbook
- Attachment 13: Mental Health (MH) Referral Training Verification
- Attachment 14: Work Order & Photos (Suicide Watch Cell)
- Attachment 15: Suicide Watch Training Verification
- Attachment 16: Grievance- Log
- Attachment 17: Posted ICE Schedule and Hours
- Attachment 18: Chemical Munitions Posting

Additional Information and Copies

To view any of our other reports,
please visit:
www.dhs.gov/OIDO.

For further information or questions, please contact the Office of the Immigration Detention Ombudsman at:
detentionombudsman@hq.dhs.gov.