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U.S. Immigration and Customs Enforcement
Office of Professional Responsibility
Inspections and Detention Oversight Division
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**Office of Detention Oversight
Compliance Inspection**

**Enforcement and Removal Operations
ERO San Antonio Field Office**

**La Quinta-Casa do Sonho
Cotulla, Texas**

January 11-13, 2022

**COMPLIANCE INSPECTION
of the
LA QUINTA-CASA DO SONHO
Cotulla, Texas**

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COMPLIANCE INSPECTION TEAM MEMBERS



Team Lead
Inspections and Compliance Specialist
Contractor
Contractor
Unit Chief
Section Chief

ODO
ODO
Creative Corrections
Creative Corrections
ODO
ODO

FACILITY OVERVIEW

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR) Office of Detention Oversight (ODO) conducted a compliance inspection of the La Quinta-Casa do Sonho (LQCS) in Cotulla, Texas, from January 11 to 13, 2022.¹ This Emergency Family Staging Center (EFSC) opened in 2021 and is operated by Endeavors. The ICE Office of Enforcement and Removal Operations (ERO) began housing residents at LQCS in 2021 under the oversight of ERO's Field Office Director (FOD) in San Antonio (ERO San Antonio). The facility operates under the Family Residential Standards (FRS) 2020.

ERO has not assigned deportation officers to the facility. An Endeavors shelter manager handles daily facility operations and manages [REDACTED] support personnel. Selrico Services provides food services, and Loyal Source Government Services provides medical care at the facility. The facility does not hold any accreditations from any outside sources.

Capacity and Population Statistics	Quantity
ICE Resident Bed Capacity ²	[REDACTED]
Average ICE Resident Population ³	[REDACTED]
Male Resident Population (as of January 11, 2022)	[REDACTED]
Female Resident Population (as of January 11, 2022)	[REDACTED]

This was ODO's first inspection of LQCS.

¹ The specific project goal is the provision of a single-use, non-congregant residential care center that provides other related services 24 hours per day, 7 days per week, for no longer than 120 hours (with preferred an aimed length of stay to be less than 72 hours) to noncitizen families who have been approved for such services by ICE.

² Data Source: ERO Facility List Report as of January 10, 2022.

³ *Ibid.*

COMPLIANCE INSPECTION PROCESS

ODO conducts oversight inspections of ICE detention facilities with an average daily population greater than 10, and where detainees are housed for longer than 72 hours, to assess compliance with ICE national detention standards. These inspections focus solely on facility compliance with detention standards that directly affect detainee life, health, safety, and/or well-being.⁴

ODO identifies violations of ICE detention standards, ICE policies, or operational procedures as “deficiencies.” ODO also highlights instances in which the facility resolves deficiencies prior to completion of the ODO inspection. Where applicable, these corrective actions are annotated with “C” under the *Compliance Inspection Findings* section of this report.

Beginning fiscal year (FY) 2022, ODO will conduct focused reviews of under 72-hour ICE detention facilities with an average daily population (ADP) of 1 or more detainees and over 72-hour ICE detention facilities with an ADP of 1-9 detainees. Additionally, ODO will conduct unannounced inspections of ICE detention facilities, regardless of ADP of detainees, as well as reviews of ICE special/emerging detention facilities/programs. As such, these facility inspections will result in an ODO Inspection Compliance Rating. ODO will conduct a complete review of several core standards, in accordance with the facility’s new contractually required ICE National Detention Standards, which include but are not limited to Medical Care/Health Care, Medical Care (Women)/Health Care (Females), Hunger Strikes, Suicide Prevention, Food Service, Environmental Health and Safety, Emergency Plans, Use of Force and Restraints/Use of Physical Control Measures and Restraints, Special Management Units, Educational Policy (FRS only), Behavior Management (FRS only), Admission and Release, Classification, and Funds and Personal Property.

Upon completion of each inspection, ODO conducts a closeout briefing with facility and local ERO officials to discuss preliminary findings. A summary of these findings is shared with ERO management officials. Thereafter, ODO provides ICE leadership with a final compliance inspection report to: (i) assist ERO in developing and initiating corrective action plans; and (ii) provide senior executives with an independent assessment of facility operations. ODO’s findings inform ICE executive management in its decision-making to better allocate resources across the agency’s entire detention inventory.

⁴ ODO reviews the facility’s compliance with selected standards in their entirety.

FINDINGS BY FAMILY RESIDENTIAL STANDARDS 2020 MAJOR CATEGORIES

FRS 2020 Standards Inspected ⁵	Deficiencies
Part 1 – Safety	
Emergency Plans	5
Environmental Health and Safety	5
Sub-Total	10
Part 2 – Security	
Admission and Release	2
Sexual Abuse and Assault Prevention and Intervention	9
Sub-Total	11
Part 3 – Order	
Behavior Management	1
Sub-Total	1
Part 4 – Care	
Food Service	10
Hunger Strikes	0
Health Care	0
Health Care (Females)	0
Significant Self-harm and Suicide Prevention and Intervention	4
Sub-Total	14
Part 7 – Administration & Management	
Resident Files	0
Post Orders	0
Sub-Total	0
Total Deficiencies	36

⁵ For greater detail on ODO’s findings, see the *Compliance Inspection Findings* section of this report.

DETAINEE RELATIONS

ODO interviewed 24 residents, who each voluntarily agreed to participate. None of the residents made allegations of discrimination, mistreatment, or abuse. Most residents reported satisfaction with facility services except for the concerns listed below. ODO conducted resident interviews face-to-face and via telephone.⁶

Housekeeping Program: One resident stated he had requested a vacuum to clean the floor in his room and center staff told him he would receive a vacuum that same day, but he never received a vacuum.

- Action Taken: ODO discussed the resident's request with center leadership. On January 13, 2022, center staff brought a vacuum to the resident's room and cleaned his floor for him. The staff also noticed improper use of a trash can in the room and informed the resident on proper usage.

Recreation: One resident stated she desired time with her son in the outdoor recreation area.

- Action Taken: ODO discussed this issue with center leadership. On January 13, 2022, center staff allowed the resident outside recreation time with her son and informed her of the process to request additional recreation time.

Food Service: One resident stated her daughter's stomach became irritated after she ate beans.

- Action Taken: ODO spoke with center leadership regarding the resident's concerns. On January 13, 2022, center and medical staff discussed substituting other items in place of beans with the resident. Center staff made changes to the child's meal plan and informed food service and floor management of the changes.

COMPLIANCE INSPECTION FINDINGS

SAFETY

EMERGENCY PLANS (EP)

ODO reviewed EP policy, interviewed the regional and shelter managers, and found the facility did not mark the center's contingency plans as "CONFIDENTIAL" (**Deficiency EP-38**⁷).

ODO reviewed the center's EP program and found the center did not have written policy and procedures addressing the following items: command post; staff recall; staff assembly; emergency response components; use of force; records and logs; utility shutoff; and center security (**Deficiency EP-41**⁸).

⁶ For family units in which at least one family member tested positive for COVID-19, ODO conducted those interviews via telephone. ODO conducted all other interviews face-to-face.

⁷ "Electronic files containing the Center's contingency plans will be marked CONFIDENTIAL." See ICE FRS, Standard, Emergency Plans, Section, (C)(3).

⁸ "Each Center will establish written policy and procedures addressing, at a minimum:

ODO reviewed the EP program and found no established emergency response agreements or memorandum of understanding (MOU) with local, state, or federal agencies (**Deficiency EP-66**⁹).

ODO reviewed the center's EP policy, interviewed the regional and shelter managers, and found no written procedures for: intensified security; security key access; nor evidence seizure and preservation (**Deficiency EP-76**¹⁰).

ODO reviewed the center's EP policy and contingency plans and found no mention of a procedure for staff to notify nearby businesses and residents of emergency situations, including the type of emergency, actions taken, evacuation routes (if applicable), and special precautions (**Deficiency EP-85**¹¹).

ENVIRONMENTAL HEALTH & SAFETY (EHS)

ODO interviewed the environmental health and safety manager, conducted an on-site environmental health and safety inspection, and found no conspicuous hazard warning signs to mark the laundry room, an area for potential injuries (**Deficiency EHS-29**¹²).

ODO interviewed the environmental health and safety manager, conducted an on-site environmental health and safety inspection, and found the center did not have an eye wash station near hazardous materials in the laundry room, in accordance with Occupational Safety and Health Administration (OSHA) standards (**Deficiency EHS-30**¹³).

-
- Chain of command;
 - Command post/center;
 - Staff recall;
 - Staff assembly;
 - Emergency response components;
 - Use of force;
 - Video recording;
 - Records and logs;
 - Utility shutoff;
 - Employee conduct and responsibility;
 - Public relations; and
 - Center security.

See ICE FRS, Standard, Emergency Plans, Section, (D).

⁹ "If the Center does not have the capacity to establish or maintain these emergency response components, then the Center Administrator will develop formal agreements or MOUs with local, State, or Federal agencies, as appropriate, for these resources." *See* ICE FRS, Standard, Emergency Plans, Section, (D)(5).

¹⁰ "The Center Administrator will provide written procedures for:

- Intensified security;
- Security key access (including issuance and accountability, drop chute, etc.); and
- Evidence seizure and preservation."

See ICE FRS, Standard, Emergency Plans, Section, (D)(10).

¹¹ "The plan will specify how and when staff will notify nearby businesses and residents of emergency situations, including the type of emergency, actions being taken, evacuation routes (if applicable), and special precautions." *See* ICE FRS, Standard, Emergency Plans, Section, (D)(16).

¹² "Protective eye, face, and other appropriate equipment (such as footwear, gloves, gowns, and/or aprons) is required where a reasonable probability of injury exists ... Areas of the Center where such injuries can occur will be marked conspicuously with hazard warning signs." *See* ICE FRS, Standard, Environmental Health and Safety, Section, (B)(2).

¹³ "Eyewash stations will be installed in close proximity to where hazardous materials are used most often, in accordance with OSHA standards." *See* ICE FRS, Standard, Environmental Health and Safety, Section, (B)(2).

ODO interviewed the environmental health and safety and shelter managers, reviewed the inventory logs for nine hazardous products, and found no separate inventory logs for these products in the laundry room (**Deficiency EHS-32¹⁴**).

Corrective Action: Before the conclusion of the inspection, the staff implemented and maintained inventory records for each laundry room product (**C-1**).

ODO conducted an on-site environmental health and safety inspection and found the instructions on the posted emergency exit diagrams printed only in English; however, residents speak predominantly Spanish (**Deficiency EHS-102¹⁵**).

Corrective Action: Before the conclusion of the inspection, the staff posted diagrams with corresponding instructions printed in English, Spanish, and Portuguese (**C-2**).

ODO toured the facility, interviewed the environmental health and safety manager, the shelter manager, and the health services administrator (HSA), and found the facility did not maintain clean-up kits for blood and body fluid spills (**Deficiency EHS-187¹⁶**).

Corrective Action: Before the conclusion of the inspection, the environmental health and safety manager and HSA bought and placed suitable clean-up kits for blood and body fluid spills (**C-3**).

SECURITY

ADMISSION & RELEASE (AR)

ODO observed the admission of residents to the center, reviewed screening materials, and found the center did not assess the risk of residents for sexual victimization (**Deficiency AR-57¹⁷**).

¹⁴ “Inventory records will be maintained separately for each substance.” See ICE FRS, Standard, Environmental Health and Safety, Section, (B)(3).

¹⁵ “In addition to a general area diagram, the following information must be posted on emergency exit diagrams: ...
• Instructions in English, Spanish, and the next most prevalent language at the Center.” See ICE FRS, Standard, Environmental Health and Safety, Section, (C)(5).

¹⁶ “A suitable cleanup kit will be maintained for use in cases of spills of blood and body fluids.” See ICE FRS, Standard, Environmental Health and Safety, Section, (D)(6).

¹⁷ “The Center also will consider, to the extent that the information is available, the following criteria to assess residents for risk of sexual victimization:

- Whether the resident has a mental, physical, or developmental disability;
- The age of the resident;
- The physical build and appearance of the resident;
- Gender;
- Although Centers generally do not house residents with criminal backgrounds, staff will ask all residents:
 - Whether the resident has been incarcerated or detained previously;
 - The nature of the resident’s criminal history; and
 - Whether the resident has any convictions for sex offenses against an adult or minor.
- Whether the resident has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, or has been diagnosed with gender identity dysphoria;
- Whether the resident has self-identified as having experienced sexual victimization previously; and
- The resident’s own concerns about his/her physical safety.”

See ICE FRS, Standard, Admission and Release, Section, (D)(6).

ODO observed admission of residents to the center, reviewed screening materials, and found the initial screening does not consider prior acts of sexual assault and abuse (SAA), prior convictions for violent offenses, nor history of prior institutional violence or SAA in assessing residents for risk of being sexually abusive (**Deficiency AR-58¹⁸**).

SEXUAL ABUSE & ASSAULT PREVENTION & INTERVENTION (SAAPI)

ODO reviewed the center's SAAPI program and found the center did not include in its written procedures: staff responsibility to report SAA allegations or suspicions; requirements to ensure the proper reporting of each allegation and suspicion; a guarantee for residents' access to multiple, effective avenues for privately reporting (SAA, retaliation for reporting SAA, or staff misconduct or violations of responsibilities contributing to such instances); nor a method to receive third-party reports of SAA in the center, with information publicly available to report SAA on behalf of a resident (**Deficiency SAAPI-4¹⁹**).

ODO reviewed the center's SAAPI program and found no written procedures for offering immediate protection, including prevention of retaliation, along with medical and mental health, legal, and safety referrals (**Deficiency SAAPI-5²⁰**).

ODO reviewed the center's SAAPI policy and found no requirement to cooperate with all audits and monitoring of center compliance with SAA policies and standards (**Deficiency SAAPI-9²¹**).

ODO reviewed the center's SAAPI policy, interviewed the regional manager, and found the FOD had not reviewed and approved the center's SAAPI policy and procedures (**Deficiency SAAPI-10²²**).

ODO reviewed the center's SAAPI policy and procedures and found the center was not in full compliance with all SAAPI standard requirements within 90 days of the center's adoption of the

¹⁸ "The initial screening will consider prior acts of SAA, prior convictions for violent offenses, and history of prior institutional violence or SAA, as known to the Center, in assessing residents for risk of being sexually abusive." See ICE FRS, Standard, Admission and Release, Section, (D)(6).

¹⁹ "Procedures for immediate reporting of SAA allegations, including:

- Responsibility of all staff to report allegations or suspicions of SAA;
- Written documentation requirements to ensure that each allegation or suspicion is reported and addressed properly;
- Guarantee that residents have multiple, effective avenues for privately reporting: SAA, retaliation for reporting SAA, or staff misconduct or violations of responsibilities that may have contributed to such instances; and
- A method to receive third-party reports of SAA in its Center, with information made available to the public regarding how to report SAA on behalf of a resident."

See ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (A).

²⁰ "Procedures for prompt and effective intervention to address the safety and treatment needs of resident victims if an alleged SAA occurs, including: ...

- Procedures for offering immediate protection, including prevention of retaliation, along with medical and mental health, legal, and safety referrals."

See ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (A).

²¹ "A requirement to cooperate with all audits and monitoring of Center compliance with SAA policies and standards." See ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (A).

²² "The Center's written policy and procedures require the review and approval of the FOD." See ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (A).

SAAPI standard (**Deficiency SAAPI-11**²³).

ODO reviewed the center's SAAPI policy, interviewed staff, and found no compliance with the FRS 2020 requirement for the center to adopt the SAAPI standard within 90 days (**Deficiency SAAPI-12**²⁴).

ODO reviewed the center's classification and screening form and found the center does not consider, to the extent the information is available, the following criteria to assess residents for risk of sexual victimization:

- whether the resident has a mental, physical, or developmental disability;
- the age of the resident;
- the physical build and appearance of the resident;
- whether the resident was incarcerated or detained previously;
- the nature of the resident's criminal history;
- whether the resident has any convictions for sex offenses against an adult or minor;
- whether the resident has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; and

the resident's own concerns about his/her physical safety (**Deficiency SAAPI-54**²⁵).

ODO reviewed the center's initial screening process and the screening classification form and found the initial screening does not consider prior acts of SAA, prior convictions for violent offenses, a resident's history of prior institutional violence or SAA, as known to the center, in assessing residents for risk of sexual victimization (**Deficiency SAAPI-55**²⁶).

ODO interviewed the prevention of sexual assault compliance manager, the general manager, and the shelter manager, and found, although not having an SAA incident, the center did not have a secure area to maintain all case records associated with allegations of SAA, including incident reports, investigative reports, offender information, case disposition, medical and counseling

²³ "The Center Administrator will ensure that, within 90 days of the adoption of this standard, written policies and procedures are in place, and that the Center is in full compliance with its requirements and guidelines." *See* ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (A).

²⁴ "The Center must meet all other requirements in this standard on the date the standard is adopted." *See* ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (A).

²⁵ "The Center will consider, to the extent that the information is available, the following criteria to assess residents for risk of sexual victimization:

- Whether the resident has a mental, physical, or developmental disability;
- The age of the resident;
- The physical build and appearance of the resident;
- Whether the resident has been incarcerated or detained previously;
- The nature of the resident's criminal history;
- Whether the resident has any convictions for sex offenses against an adult or minor;
- Whether the resident has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
- The resident's own concerns about his/her physical safety."

See ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (H)(1).

²⁶ "The initial screening will consider prior acts of SAA, prior convictions for violent offenses, and history of prior institutional violence or SAA, as known to the Center, in assessing residents for risk of sexual victimization." *See* ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (H)(1).

evaluation findings, and recommendations for post-release treatment (**Deficiency SA-API-143**²⁷).

ORDER

BEHAVIOR MANAGEMENT (BM)

ODO reviewed the facility handbook and found it did not inform residents of their right for protection from:

- personal abuse;
- corporal punishment;
- unnecessary or excessive use of force;
- personal injury;
- disease;
- property damage and harassment; and
- the right to freedom from discrimination based on race, religion, national origin, gender, sexual orientation, physical or mental ability, or political beliefs (**Deficiency BM-13**²⁸).

CARE

FOOD SERVICE (FS)

ODO interviewed the environmental health and safety and shelter managers, conducted an on-site environmental health inspection of the kitchen, and found the center had not established a system to control the use and storage of knives (**Deficiency FS-7**²⁹).

Additionally, ODO found the following deficiencies because the center did not establish a system to control the use and storage knives:

- The center did not store knives in a shadow-boarded, locked cabinet (**Deficiency FS-8**³⁰);
- The center stored two 8-inch knives in a cabinet drawer without an approved locking

²⁷ “Each Center will maintain in a secure area all case records associated with allegations of SAA, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary.” See ICE FRS, Standard, Sexual Assault and Abuse Prevention and Intervention, Section, (N).

²⁸ “Residents will have the following rights and will receive notice of them in the handbook:

- The right to protection from personal abuse, corporal punishment, unnecessary or excessive use of force, personal injury, disease, property damage and harassment;
- The right to freedom from discrimination based on race, religion, national origin, gender, sexual orientation, physical or mental ability, or political beliefs;
- The right to pursue a grievance in accordance with procedures provided in the resident handbook, without fear of retaliation;
- The right to pursue a grievance in accordance with the Family Residential Standard on Grievance System and procedures provided in the resident handbook.
- The right to correspond with persons or organizations, consistent with safe and secure Center operations; and
- The right to due process, including the prompt resolution of a disciplinary matter.”

See ICE FRS, Standard, Behavior Management, Section, (A).

²⁹ “Centers will establish a system to control the use and storage of knives.” See ICE FRS Standard, Food Service, Section (B)(2).

³⁰ “Knives will be stored in a shadow-boarded, locked cabinet.” See ICE FRS Standard, Food Service, Section (B)(2).

- device (**Deficiency FS-9**³¹);
- The center did not inventory and store knives in accordance with the ICE FRS for tool control (**Deficiency FS-13**³²); and
- The center did not maintain a knife cabinet which met the tool-control standards of the OSHA, as well as any applicable state or local standards (**Deficiency FS-19**³³).

Corrective Action: Before the conclusion of the inspection, the environmental health and safety manager removed the knives from the center property for proper disposal. Selrico Services prepares all resident meals outside of the center and delivers the prepared meals to the center, and the center has no need to keep knives on the property (**C-4**).

ODO reviewed the center’s FS menus, interviewed the environmental health and safety and shelter managers, and found:

- The facility follows a standard 14-day menu cycle, not the ICE/ERO 35-day cycle menu required by the FS standard (**Deficiency FS-92**³⁴);
- A registered dietitian with experience in both adult and pediatric nutrition did not conduct a complete nutritional analysis of every master-cycle menu planned by the center’s administration to ensure meals meet U.S. Recommended Daily Allowances (RDA) (**Deficiency FS-99**³⁵); and
- A registered dietitian did not certify the menus before the center incorporated them into the food service program (**Deficiency FS-100**³⁶).

ODO reviewed the center’s FS menus, interviewed the environmental health and safety and shelter managers, and found a food service administrator (FSA) did not certify the menus in exceeding minimum daily nutritional requirements and meeting RDAs (**Deficiency FS-189**³⁷).

ODO reviewed the center’s FS menus, interviewed the environmental health and safety and shelter managers, and found an FSA or a registered dietician did not certify common fare menus in meeting RDAs (**Deficiency FS-212**³⁸).

³¹ “The knife cabinet must be equipped with an approved locking device.” See ICE FRS Standard, Food Service, Section (B)(2).

³² “Knives will be inventoried and stored in accordance with the ICE Family Residential Standard on Tool Control.” See ICE FRS Standard, Food Service, Section (B)(2).

³³ “The knife cabinet will meet the tool-control standards of the federal Occupational Safety and Health Administration (OSHA), as well as any applicable state or local standards and site-specific standards developed by the Center.” See ICE FRS Standard, Food Service, Section (B)(2).

³⁴ “The ICE/ERO standard menu cycle is 35 days.” See ICE FRS Standard, Food Service, Section (E)(1).

³⁵ “A registered dietitian with experience in both adult and pediatric nutrition will conduct a complete nutritional analysis that meets U.S. Recommended Daily Allowances (RDA), at least yearly, of every master-cycle menu planned by the FSA.” See ICE FRS Standard, Food Service, Section (E)(2).

³⁶ “The dietitian must certify menus before they are incorporated into the food service program.” See ICE FRS Standard, Food Service, Section (E)(2).

³⁷ “The menus must be certified by the FSA as exceeding minimum daily nutritional requirements and meeting RDAs.” See ICE FRS Standard, Food Service, Section (G)(2).

³⁸ “Common fare menus will meet RDAs.” See ICE FRS Standard, Food Service, Section (G)(7).

SIGNIFICANT SELF-HARM & SUICIDE PREVENTION & INTERVENTION (SSHPI)

ODO interviewed the HSA, reviewed Endeavors’ mental health services procedure and policy on disclosure of suicide, homicide, or imminent dangers, and found the center did not have a program, which included a multidisciplinary suicide prevention committee, that the clinical medical authority established and approved, nor approved and signed by the HSA and shelter manager (**Deficiency SSHPI-1³⁹**).

ODO interviewed the HSA, reviewed Endeavors’ mental health services procedure and policy on disclosure of suicide, homicide, or imminent dangers, and found the center did not have a multidisciplinary suicide prevention committee made up of representatives from supervisory, mental health, and medical staff (**Deficiency SSHPI-3⁴⁰**).

ODO interviewed the HSA, reviewed Endeavors’ mental health services procedure and policy on disclosure of suicide, homicide, or imminent dangers, and found the center did not have a multidisciplinary suicide prevention committee that meets at least on a quarterly basis (**Deficiency SSHPI-4⁴¹**).

ODO reviewed the center’s suicide observation training curriculum and found no training covering:

- demographic, cultural, and precipitating factors of self-harm or suicidal behavior;
- environmental concerns;
- factors of living at the center contributing to suicidal behavior;
- recognizing verbal and behavioral cues indicating potential suicide;
- nor liability issues associated with resident suicide (**Deficiency SSHPI-11⁴²**).

ADMINISTRATION AND MANAGEMENT

RESIDENT FILES (RF)

ODO observed the admission and release process and attempted to review resident files. ODO requested clarification from ERO headquarters staff and learned the EFSCs do not maintain resident files on-site because of security considerations. As such, ODO was unable to verify all resident file requirements and noted the following **Areas of Concern**:

³⁹ “Each Center will have a written self-harm and suicide prevention and intervention program, including a multidisciplinary suicide prevention committee, that will be reviewed and approved by the Clinical Medical Authority (CMA), and approved and signed by the Health Services Administrator (HSA) and Center Administrator.” *See* ICE FRS Standard, Significant Self-Harm and Suicide Prevention and Intervention, Section (A).

⁴⁰ “The multidisciplinary suicide prevention committee shall, at a minimum, comprise representatives from supervisory, mental health, and medical staff.” *See* ICE FRS Standard, Significant Self-Harm and Suicide Prevention and Intervention, Section (A).

⁴¹ “The committee shall meet on at least a quarterly basis to provide input regarding all aspects of the Center’s suicide prevention and intervention program, including suicide prevention policies and staff training.” *See* ICE FRS Standard, Significant Self-Harm and Suicide Prevention and Intervention, Section (A).

⁴² “All the following topics should be incorporated into the required self-harm and suicide prevention training: demographic, cultural, and precipitating factors of self-harm or suicidal behavior; environmental concerns; factors of living at the Center that can contribute to suicidal behavior; recognizing verbal and behavior cues that indicate potential suicide; liability issues associated with resident suicide.” *See* ICE FRS Standard, Significant Self-Harm and Suicide Prevention and Intervention, Section (B).

- ODO could not verify the resident files contained originals or copies of all forms or their equivalents;
- ODO could not review and confirm resident intake documentation listed in section (B) of the Resident Files standard;
- ODO could not verify if the center closed or archived a resident file upon the last family member’s discharge from the center; and
- ODO could not verify if center staff added discharge documents to the resident files.

CONCLUSION

During this inspection, ODO assessed the facility’s compliance with 12 standards under FRS 2020 and found the facility in compliance with 5 of those standards. ODO found 36 deficiencies in the remaining 7 standards. LQCS became an EFSC, serving family units, 4 months before the inspection, and ODO found the center’s staff to be both knowledgeable and professional. ODO recommends ERO work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations. A uniform corrective action plan was not required for LQCS as this was ODO's first inspection of LQCS.

Compliance Inspection Results Compared	FY 2021 (FRS 2020)	FY 2022 (FRS 2020)
Standards Reviewed	N/A	12
Deficient Standards	N/A	7
Overall Number of Deficiencies	N/A	36
Repeat Deficiencies	N/A	N/A
Areas of Concern	N/A	4
Corrective Actions	N/A	4
Facility Rating	N/A	Acceptable/Adequate