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Office of Professional Responsibility
ICE Inspections
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Office of Detention Oversight
Compliance Inspection

Enforcement and Removal Operations
ERO San Francisco Field Office

Mesa Verde ICE Processing Center
Bakersfield, California

December 6-8, 2022

COMPLIANCE INSPECTION
of the
MESA VERDE ICE PROCESSING CENTER
Bakersfield, California

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COMPLIANCE INSPECTION TEAM MEMBERS

[redacted]	Acting Team Lead	ODO
	Senior Inspections and Compliance Specialist	ODO
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	Senior Inspections and Compliance Specialist	ODO
	Contractor	Creative Corrections
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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 Mesa Verde ICE Processing Center (MVIPC) in Bakersfield, California, from December 6 to 8, 2022.[1] The facility opened in 2015 and is owned and operated by The GEO Group, Inc. (GEO). The ICE Office of Enforcement and Removal Operations (ERO) began housing detainees at MVIPC in 2015 under the oversight of ERO's Field Office Director in San Francisco (ERO San Francisco). The facility operates under the Performance-Based National Detention Standards (PBNDS) 2011 (Revised 2016).

ERO does not have any staff assigned to the facility. A facility administrator handles daily operations and manages [redacted] support personnel. GEO provides food services and medical care, and Union Supply Group provides commissary services at the facility. The facility was accredited by the American Correctional Association in January 2020 and the National Commission on Correctional Health Care in January 2021. In March 2021, MVIPC was audited for the Department of Homeland Security (DHS) Prison Rape Elimination Act (PREA) and was DHS PREA certified.

Capacity and Population Statistics	Quantity
ICE Bed Capacity[2]	[redacted]
Average ICE Population[3]	[redacted]
Adult Male Population (as of December 6, 2022)	[redacted]
Adult Female Population (as of December 6, 2022)	[redacted]

During its last inspection, in Fiscal Year (FY) 2022, ODO found eight deficiencies in the following areas: Funds and Personal Property (2); Hunger Strikes (2); Medical Care (2); Significant Self-harm and Suicide Prevention and Intervention (1); and Special Management Units (1).

[1] This facility holds both male and female detainees with low, medium-low, medium-high, and high security classification levels for periods greater than 72 hours.
[2] Data Source: ERO Facility List as of December 5, 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 over 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 highlights instances when 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.

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 their 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 PERFORMANCE-BASED NATIONAL DETENTION STANDARDS 2011 (REVISED 2016) MAJOR CATEGORIES

PBNDS 2011 (Revised 2016) Standards Inspected[5,6]	Deficiencies
Part 1 - Safety	
Emergency Plans	0
Environmental Health and Safety	3
Transportation (by Land)	0
Sub-Total	**3**
Part 2 - Security	
Admission and Release	0
Custody Classification System	0
Contraband	0
Funds and Personal Property	0
Hold Rooms in Detention Facilities	1
Key and Lock Control	0
Sexual Abuse and Assault Prevention and Intervention	0
Special Management Units	0
Tool Control	12
Use of Force and Restraints	0
Sub-Total	**13**
Part 3 - Order	
Disciplinary System	0
Sub-Total	**0**
Part 4 - Care	
Food Service	0
Medical Care	3
Medical Care (Women)	0
Significant Self-harm and Suicide Prevention and Intervention	6
Terminal Illness, Advance Directives and Death	0
Disability Identification, Assessment, and Accommodation	0
Sub-Total	**9**
Part 5 - Activities	
Correspondence and Other Mail	0
Recreation	0

[5] For greater detail on ODO's findings, see the *Compliance Inspection Findings* section of this report.
[6] Beginning in FY 2022, ODO instituted a process of rotating all standards on a 3-year basis. As a result, some standard components may not be present in all standards.

Visitation	0
Sub-Total	**0**
Part 6 - Justice	
Detainee Handbook	0
Sub-Total	**0**
Part 7 - Administration and Management	
Staff Training	0
Sub-Total	**0**
Total Deficiencies	**25**

DETAINEE RELATIONS

ODO interviewed six detainees, who each voluntarily agreed to participate. ODO remained in the interview area for four more hours to extend availability to the detainees, but no additional detainees volunteered for an interview. None of the detainees made allegations of discrimination, mistreatment, or abuse. Most detainees reported satisfaction with facility services except for the concerns listed below.

Food Service: One detainee stated the facility served beans and rice every day.

- Action Taken: ODO interviewed the facility kitchen staff, reviewed food service logs and the facility's menus, observed a lunch meal, and found a registered dietitian approved the menus, containing an appropriate 35-day meal rotation without any evidence of the facility serving beans and rice daily.

Food Service: One detainee stated the facility served a substitute meat that had a distinct odor.

- Action Taken: ODO reviewed the menu and found a registered dietitian approved the menu, containing an appropriate 35-day meal rotation with no plant-based meats. ODO observed a lunch meal and noticed no unusual odors coming from the served foods.

Medical Care: One detainee stated his concern over the lack of privacy about his medical condition, his doctor visits, and personal information. He also stated his embarrassment when an officer stands next to an examination room and can hear his conversation with medical staff.

- Action Taken: ODO spoke with facility medical staff and found the MVIPC annually trains and certifies all officers in the Health Insurance Portability and Accountability Act (HIPAA). Facility staff explained to the detainee how an officer posted near an examination room provides the required security in the medical section and HIPAA safeguards a detainee's medical records and personal information. The detainee acknowledged understanding.

Sexual Abuse and Assault Prevention and Intervention: One detainee stated he spent 28 days in the Restrictive Housing Unit (RHU) before MVIPC cleared him of a PREA allegation.

- Action Taken: ODO spoke to the facility's PREA coordinator and reviewed the associated PREA file, administrative segregation order, and the administrative segregation reviews for the detainee. The detainee spent 28 days in the RHU (administrative segregation) for an alleged PREA violation, during which time, the facility conducted all required segregation reviews and provided written notification to the detainee of his right to appeal following each review. The facility released the detainee from administrative segregation on July 7, 2022, following his 28-day administrative segregation review. Additionally, the facility conducted a PREA investigation into the alleged PREA incident and on August 16, 2022, the facility investigator found the allegation to be substantiated. The facility conducted a disciplinary hearing and the facility disciplinary panel found the detainee guilty for assaulting another person and sanctioned him to time served.

COMPLIANCE INSPECTION FINDINGS

SAFETY

ENVIRONMENTAL HEALTH AND SAFETY (EHS)

ODO toured the facility, reviewed hazardous substance inventories and 111 Safety Data Sheets (SDS), and found the following deficiencies:

- The facility did not maintain current inventories of hazardous substances (flammable, toxic, or caustic) in designated storage areas. Specifically, the barbershop's hazardous chemical inventory listed one container of disinfectant and one container of Blade Care cleaner and lubricant. However, ODO observed two containers of disinfectant and no Blade Care products in use or stored in the barbershop **(Deficiency EHS-39[7])**;
- Three out of 111 SDS files did not contain the latest issuance from the manufacturer: a multi-purpose cleaner, dated August 5, 2015, instead of December 20, 2020; a disinfectant, dated July 9, 2012, instead of May 17, 2022; and Pepper Ball Tactical Powder, dated March 13, 2013, instead of August 11, 2015 **(Deficiency EHS-47[8])**; and
- Inventory records of hazardous substances not kept current before, during, and after

[7] "Every area shall maintain a current inventory of the hazardous substances (e.g., flammable, toxic or caustic) used and stored there." *See* ICE PBNDS 2011 (Revised 2016), Standard, Environmental Health and Safety, Section (V)(B)(3).

[8] "Because changes in MSDSs occur often and without notice, staff must:

1. Review the latest issuance from the manufacturers of the relevant substances;
2. Update the MSDS files as necessary; and
3. Forward any changes to the maintenance supervisor, so that the copy is kept current."

See ICE PBNDS 2011 (Revised 2016), Standard, Environmental Health and Safety, Section (V)(B)(4)(d)(1-3).

each use. Specifically, the barbershop hazardous chemical inventory listed one container of disinfectant and one container of Blade Care, but ODO observed two containers of disinfectant and no Blade Care products in the barbershop **(Deficiency EHS-53[9])**.

SECURITY

HOLD ROOMS IN DETENTION FACILITIES (HRDF)

ODO observed the facility hold rooms and found no floor drains in any of the three hold rooms of the facility intake area **(Deficiency HRDF-11[10])**.

TOOL CONTROL (TC)

ODO reviewed the facility tool control policy and found no established policy on tool use and storage, to include separate lists for restricted and non-restricted tools. Specifically, the facility listed both restricted and non-restricted tools together **(Deficiency TC-35[11])**.

ODO interviewed the facility maintenance supervisor and found each department head responsible for implementing tool control procedures in his/her department did not retain a third copy of the class "R" tool inventory **(Deficiency TC-54[12])**.

ODO interviewed the facility maintenance supervisor and found the maintenance supervisor and the health services administrator did not review nor revise monthly class "R" tool inventories for their departments. Instead, the maintenance supervisor reviewed all tool inventories quarterly **(Deficiency TC-57[13])**.

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[9] "Inventory records for a hazardous substance must be kept current before, during and after each use." *See* ICE PBNDS 2011 (Revised 2016), Standard, Environmental Health and Safety, Section (V)(B)(6)(d).

[10] "Each hold room shall have floor drain(s)." *See* ICE PBNDS 2011 (Revised 2016), Standard, Hold Rooms in Detention Facilities, Section (V)(A)(7).

[11] "The facility administrator shall establish a policy document on facility tool use and storage that includes separate, comprehensive, alphabetical lists of both restricted and non-restricted tools." *See* ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(C).

[12] "Each department head is responsible for implementing tool control procedures in that department, and the following procedures are specifically required of the facility maintenance department head, health services administrator (HSA), food service manager, electronics technician, recreation specialist and senior firearms instructor: …

4. Retain a third copy in the department;"

See ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(F)(4).

[13] "Each department head is responsible for implementing tool control procedures in that department, and the following procedures are specifically required of the facility maintenance department head, health services administrator (HSA), food service manager, electronics technician, recreation specialist and senior firearms instructor: …

5. Review and where necessary revise the class "R" tool inventory on a regular schedule: …

b. Monthly—facility maintenance, medical, and…"

See ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(F)(5)(b).

ODO reviewed the facility master tool inventory and found each department head was responsible for implementing tool control procedures in his/her department, but they did not include the date of issuance/revision on all inventory sheets. Specifically, only the first page of each departmental inventory sheet included the date of issuance/revision **(Deficiency TC-61[14])**.

ODO interviewed the facility maintenance supervisor and found the maintenance supervisor did not provide the chief of security (COS) a Master Tool Inventory Sheet (MTIS) for restricted and non-restricted tools. Specifically, the maintenance supervisor did not provide separate inventories for restricted and non-restricted tools **(Deficiency TC-103[15])**.

ODO reviewed the facility policy, interviewed the facility maintenance supervisor, and found the COS did not assign an officer to monitor the quarterly inventories. Specifically, only the maintenance supervisor and the department head conducted inventories for each department **(Deficiency TC-105[16])**.

ODO reviewed the facility MTIS for each department and found the officer did not clearly initial the bottom of each form to certify a check of all records and completion of all inventories **(Deficiency TC-106[17])**.

ODO reviewed the facility master tool inventory and found the maintenance supervisor did not keep a separate file folder for each shop or tool storage area **(Deficiency TC-107[18])**.

ODO reviewed the facility master tool inventory folder and found no MTIS on the left side of the folder **(Deficiency TC-108[19])**.

ODO reviewed the facility master tool inventory and found no retyping or reprinting of the page for any addition or deletion made to the master inventory nor any inserting of it into the master inventory. Specifically, the changes were crossed out on the master inventory **(Deficiency TC-**

[14] "Each department head is responsible for implementing tool control procedures in that department, and the following procedures are specifically required of the facility maintenance department head, health services administrator (HSA), food service manager, electronics technician, recreation specialist and senior firearms instructor: …

8. Include on all inventory sheets the date of issuance/revision."

See ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(F)(8).

[15] "The tool control officer shall provide the Chief of Security a complete set of the separate inventories (e.g., restricted tools, non-restricted tools) referred to as the Master Tool Inventory Sheet." *See* ICE PBNDS 2011 (Revised), Standard, Tool Control, Section (V)(J)(5)(a)(2).

[16] "The Chief of Security shall assign an officer to monitor the quarterly inventories." *See* ICE PBNDS 2011 (Revised 2016, Standard, Tool Control, Section (V)(J)(5)(b).

[17] "This officer shall clearly initial the bottom of each form certifying that the records have been checked and all inventories completed." *See* ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(J)(5)(b).

[18] "The facility administrator's designee shall maintain a separate file folder for each shop or area in which tools are stored." *See* ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(J)(6).

[19] "The left side of the folder shall contain the master tool inventory sheet(s)." *See* ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(J)(6)(a).

109[20]).

ODO reviewed the facility master tool inventory and found staff destroyed original pages when making an addition or deletion, instead of moving the original pages to the right side of the folder **(Deficiency TC-110[21])**.

ODO reviewed the facility master tool inventory and found no documentation for inventory additions or deletions on the right side of the folder **(Deficiency TC-112[22])**.

CARE

MEDICAL CARE (MC)

ODO reviewed 2 facility medical policies and facility pharmacy inventory records and found 124 Easy Touch insulin syringes stored in the pharmacy, but the Easy Touch insulin syringe perpetual inventory reflected 129 Easy Touch insulin syringes **(Deficiency MC-92[23])**.

ODO reviewed [redacted] medical staff credential files and found [redacted] out of [redacted] credential files did not contain verifiable licensing of staff in compliance with applicable state and federal requirements. Specifically, ODO found two physician credential files did not contain verifications by the Medical Board of California License Verification System **(Deficiency MC-101[24])**. **This is a repeat deficiency**.

ODO reviewed 10 detainee medical files for detainees prescribed psychotropic medication and found in 5 out of 10 medical files, no documented informed consent form prior to administering psychotropic medications. Specifically, ODO found medical staff left 1 consent form incomplete and completed the other 4 forms between 6 and 18 days after administering the medication **(Deficiency MC-241[25])**. **This is a repeat deficiency**.

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[20] "When an addition or deletion is made to the master inventory, the page on which the change is made shall be completely retyped or reprinted and inserted into the master inventory." *See* ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(J)(6)(a).

[21] "Staff shall not destroy any of the original pages, but shall move them to the right side of the folder for future reference." *See* ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(J)(6)(a).

[22] "The right side of the folder shall also contain documentation including, but not limited to: …

2) Requests for inventory additions or deletions;"

See ICE PBNDS 2011 (Revised 2016), Standard, Tool Control, Section (V)(J)(6)(b)(2).

[23] "Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include: …

5. Secure storage and disposal and perpetual inventory of all controlled substances (DEA Schedule II-V), syringes, and needles."

See ICE PBNDS 2011 (Revised 2016), Standard, Medical Care, Section (V)(G)(5).

[24] "All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements." *See* ICE PBNDS 2011, Standard, Medical Care, Section (V)(I).

[25] "Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a

SIGNIFICANT SELF-HARM AND SUICIDE PREVENTION AND INTERVENTION (SSHSPI)

ODO reviewed [redacted] medical staff training files and [redacted] medical files of detainees placed on suicide watch and found the following deficiencies:

- In [redacted] out of [redacted] training files, no minimum 2 hours of annual suicide prevention training was completed. Specifically, [redacted] out of [redacted] medical staff completed only 1 hour of training by September 2022 **(Deficiency SSHSPI-8[26])**. **This is a repeat deficiency and a priority component**;
- In [redacted] out of [redacted] training files, there was no comprehensive suicide prevention training at least annually. Specifically, [redacted] out of [redacted] medical staff received 1-hour of training **(Deficiency SSHSPI-9[27])**;
- In one out of two detainee medical files, no trained and qualified medical staff re-evaluated the detainee daily, nor did medical staff place any written re-evaluation in the record. Specifically, ODO found medical staff did not conduct nor document 26 out of 50 daily re-evaluations **(Deficiency SSHSPI-26[28])**;
- In 2 out of 2 detainee medical files, no documented continuous monitoring at least every 15 minutes. Specifically, ODO found in 71 entries from 2 suicide watch logs in which facility staff documented continuous monitoring between 16 and 43 minutes **(Deficiency SSHSPI-34[29])**. **This is a priority component**;
- In one out of two detainee medical files, no welfare checks at least every 8 hours. Specifically, ODO found medical staff conducted 42 welfare checks between 10 and 35 hours **(Deficiency SSHSPI-35[30])**. **This is a repeat deficiency**; and
- In one out of two detainee medical files, no re-assessment of the detainee within 72

description of the medication's side effects, shall be obtained." *See* ICE PBNDS 2011 (Revised 2016), Standard, Medical Care, Section (V)(AA)(4).

[26] "All facility staff members who interact with and/or are responsible for detainees shall receive comprehensive suicide prevention training, during orientation and at least annually." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(A).

[27] "Initial suicide prevention training for all staff responsible for supervising detainees should consist of a minimum of eight hours of instruction. Subsequent annual suicide prevention training should consist of a minimum of two hours of refresher instruction." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(A).

[28] "Detainees placed on suicide watch shall be re-evaluated by appropriately trained and qualified medical staff on a daily basis. The re-evaluation must be documented in the detainee's medical record." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(D).

[29] "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." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(F).

[30] "All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every 8 hours conducted by clinical staff, and daily mental health treatment by a qualified clinician." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(F).

hours of discharge from suicide observation. Specifically, ODO found medical staff reassessed the detainee 30 days after discharge **(Deficiency SSHSPI-56[31]). This is a priority component**.

CONCLUSION

During this inspection, ODO assessed the facility's compliance with 25 standards under PBNDS 2011 (Revised 2016) and found the facility in compliance with 20 of those standards. ODO found 25 deficiencies in the remaining 5 standards. ODO recommends ERO work with the facility to resolve any deficiencies that remain outstanding in accordance with contractual obligations. ERO provided ODO with the uniform corrective action plan for ODO's last inspection of MVIPC on June 28, 2022.

Compliance Inspection Results Compared	FY 2022 PBNDS 2011 (Revised 2016)	FY 2023 PBNDS 2011 (Revised 2016)
Standards Reviewed	18	25
Deficient Standards	5	5
Overall Number of Deficiencies	8	25
Priority Component Deficiencies	0	3
Repeat Deficiencies	0	4
Areas Of Concern	0	0
Corrective Actions	0	0
Facility Rating	Superior	Good

[31] "All detainees discharged from suicide observation should be re-assessed 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." *See* ICE PBNDS 2011 (Revised 2016), Standard, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(F)(4).