| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455485 | A. Building<br>B. Wing | 05/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avir at Petal Hill | 900 S Baxter Ave<br>Tyler, TX 75701 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 19 residents reviewed for accidents. (Resident #1). The facility failed to ensure adequate supervision and implementation of safety interventions for Resident #1 who resided on a secured unit and was assessed to be at risk for elopement. This resulted in Resident #1 exiting the building on 04/30/2026 without staff knowledge or supervision, placing the resident at risk for harm.The noncompliance was identified as PNC (past noncompliance). The IJ began on 04/30/2026 and ended on 05/06/2026. The facility had corrected the noncompliance before the survey began.This failure could place residents at risk of potential accidents, injuries, harm, or death.Findings included: A record review of a face sheet dated 04/30/2026 indicated Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dementia, psychotic disturbance (where a person loses touch with reality), anxiety, hypertension, trigeminal neuralgia (a sudden intense electric shock-like pain in the face), hyperlipidemia (high levels of lipids (fats) such as cholesterol in the blood), conversion disorder (a sudden weakness, paralysis , tremors or swallowing), with seizures or convulsions, major depressive disorder, type 2 diabetes mellitus, ischemic attack (TIA often called a mini-stroke, blockage of blood flow to the part of the brain), dysphagia (difficulty swallowing), cerebral infarction (ischemic stroke a blood vessel blocked or severely narrowed), chronic obstructive pulmonary disease (an irreversible lung disease that restricts airflow and makes breathing difficult) , and cognitive communication deficit ( impairment caused by disruptions in attention, memory, and function). Resident #1 was discharged on 05/7/2026 and transferred to a secured unit. A record review of Resident's #1 MDS dated [DATE] Section C0500: indicated Resident #1, had a BIMS score of 03 which indicated severe cognitive impairment. Section E0900: indicated wandering behavior was present and occurred with a frequency of one to three days.A record review of Resident #1's elopement risk assessment dated [DATE] indicated a score of 6 which was high risk for elopement.A record review of Resident's #1 care plans initiated on 11/6/2026, updated 4/30/2026 indicated Resident #1 resided in the secured/memory unit and was at risk for injury from wandering in an un- safe environment related to diagnosis of dementia and impaired safety awareness. The resident was at risk of injury from others while residing in secured/ memory unit due to altered cognition. On 4/30/2026, an actual elopement occurred without injury or emotional distress, and the resident was successfully returned to the facility. Intervention initiated on 4/30/2026 included the resident was placed on 1 on 1 observation. Staff were instructed to sit outside of exit door; resident room was moved closer to the nurse's station. Family and PCP in agreement with secured unit placement. Staff ensured residents safety.A record review of Resident #1's police report indicated the incident was reported on 4/30/2026 at 9:45 a.m. The resident was last known secured at 9:46 a.m. Officer responded to the area of two local streets regarding an elderly female, later identified as Resident #1, wandering in the neighborhood and entering a residential backyard. Dispatch contacted the facility and requested staff verify whether any residents were missing. Upon arrival, facility staff were present with Resident #1. The MDS RN arrived on scene and<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | assisted Resident #1 back to the facility without incident. The MDS RN reported Resident #1 exited through a secured door that had not been properly closed, allowing the resident to leave the facility unsupervised.A record review of Medical Records/CNA B's typed and signed statement on 4/30/2026 at 9:49 a.m., indicated the police department contacted the facility regarding a white female with gray hair, located approximately one block away. Once CNA B received the call, she informed the Director of Nursing (DON) to conduct a resident count while she went to identify the individual. Upon arrival, she confirmed that the individual was one of the facility residents. After identification was verified, the DON, MDS nurse, and Administrator arrived on the scene, and the resident was safely escorted back to the facility. A record review of Resident #1's provider investigation report dated 4/30/2026 at 12:30 p.m. indicated Resident #1 was seen at activity at 9:45 a.m. Within a 4-minute time frame the resident walked out of the rear exit of the secured unit. The facility was notified by the police department about an older lady in a person's backyard. The police notified Resident #1 was located 4/30/2026 at 10:00 a.m. on a sidewalk of a local street. A record review of Resident #1's progress notes dated 4/30/2026 at 4:39 p.m. indicated the IDT met to discuss the PD notified staff that there was a resident outside of the premises on 4/302026 at 9:49 a.m. A facility head count and search of the immediate perimeter was initiated. The IDT care notes indicated, a member of the management found the resident walking on the sidewalk and immediately notified the DON, ADM, and MDS RN. ADM, DON, and MDS RN, drove to location where resident was with management staff and two PD officers. the IDT care notes indicated residents returned to the facility at 10:14am and the Nurse immediately completed a head-to-toe assessment with no Injuries. [Resident #1did not show any signs and symptoms of emotional distress. Resident #1 stated I just wanted to go for a walk. A record review of Resident #1's BIMS Evaluation on 4/30/2026 at 4:09 p.m. indicated Resident #1, had a BIMS score of 10 which indicated moderate impairment. A record review of Resident #1's elopement risk assessment dated [DATE] indicated a score of 5 which was high risk for elopement.A record review of Resident #1's nurse's note dated 5/1/2026 at 3:42 p.m. indicated the DON discussed with the resident's responsible party, a possible transfer to a secured unit for increased safety. The resident's responsible party agreed with the plan, and the social worker was to be notified. A record review of Resident #1's social service notes dated 5/1/2026 at 3:52 p.m. indicated the DON informed the social worker that she had spoken with resident's RP and advised that, per corporate direction, a referral was being sent to the sister facility's memory care unit to better support the safety and security needs of the resident. A record review of Resident #1's nurse's note dated 5/7/2026 at 12:16 p.m. indicated Resident #1 was discharged to the sister facility's memory care unit at 9:00 a.m. with medications and belongings. The resident was noted to be pleasant with no behaviors or complaints of pain or discomfort. During an observation on 5/12/2026 at 11:15 a.m., revealed Resident #1 was no longer residing on the secured unit. On the secured unit several residents were in the dining area. Observed three staff members in the hallway and in the dining area of the secured unit. Staffing patterns were compliant with facility postings. Observed all exit doors locked with keypad combination and the secured locked door at the end of the hallway alarms were in working order. During an interview on 5/12/2026 at 11:45 a.m., CN/LVN J said the last time she observed Resident #1 on the day of elopement was at approximately 8:30 a.m., when she administered the resident's medications and the resident was in her room in bed. She said the resident was highly functioning and frequently paced throughout the unit, in and out of her room. CN/LVN J said she returned to the unit approximately 9:55 a.m., due to the commotion heard on the unit. She said there were two CNAs and the Activity Assistant left on the unit while she observed the residents' smoke break. CN/LVN J said Resident # 1 reportedly exited through the secured locked door at the end of the hallway; however, staff were unable to determine how the secured locked door at the end of the hallway was opened and did not hear the alarm. She said staff denied using the door for entry or exit, and for breaks and reported the keypad code had been changed after the incident. She further said the hallway cameras were not functioning, preventing review of the incident. Following the elopement, she said staff<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | received education regarding the secured door policy and Elopement Prevention and Response.During an interview on 5/12/2026 at 11:55 a.m., CNA (A) stated she last observed Resident #1 ambulating in the hallway at approximately 9:20 a.m. to 9:25 a.m. She said she was in another resident's room when she responded to the commotion on the unit. CNA (A) stated immediately a resident count was done but they were unable to locate Resident #1. She said Resident #1 frequently said she wanted to go home and often would pack her belongings. CNA (A) denied using the secured hallway door for breaks, entering and exiting, and stated staff were in-serviced not to use the back hallway secured door, only during a facility emergency. She said she had occasionally observed maintenance staff using the door. She said she was unable to determine how the resident got out the door and did not hear the alarm sound. During an interview on 5/12/2026 at 12:05 p.m., the Activity Director said she was in the secured unit the day of the incident and said she last observed Resident # 1 sitting at the table in the dining area eating and the time was approximately 9:00 a.m.; she remembered after breakfast trays were served. The Activity Director stated she was provided with in-service training on elopement prevention and the security door following the incident that occurred on 4/30/2026. During an interview on 5/12/2026 at 12:15 p.m. the ADM said the hallway camera was not functioning and had not worked since he was hired. He said the alarm was functioning at a low volume however the door was closed and locked when he arrived at the secured unit during the incident on 4/30/2026. He said he immediately questioned all staff, and the maintenance man denied entering and exiting the secured door however he was unable to determine how the resident exited the secured door. He said he immediately checked the alarm systems and turned the volume up. He said the secured door and the alarms systems were immediately checked and secured. During an interview on 5/12/2026 at 12:35 p.m., the MDS RN said the administration team was in a meeting when they were notified by the PD that a resident was missing, immediate resident count of the secured unit, and the facility was conducted. She said the alarms were not heard however the secured unit door was locked. She further stated there was a storm the day before, however, she said she was unable to determine how the resident got out the door. During an interview on 5/12/2026 at 12:45 p.m., the DON said after notification by the police department she immediately responded and went to the secured unit, an immediate conducted a count of the residents was conducted, the facility parameters were searched, however, she said there were no alarm sounds, and the secured door was locked. The DON said all staff that were interviewed denied entering and exiting the secured door. However, she said she was unable to determine how the resident got out the door. She said immediately after the resident returned to the secured unit; a head-to-toe assessment was completed. The DON said the resident was moved closer to the nurses' station for observation and placed on 1 to1 for short time, approximately two and half hours. The DON said a staff member was placed in the hallway to monitor door exits. She said the secured door and the alarms systems were immediately checked and secured. The DON said immediate steps were taken to make sure all residents' elopement assessments were completed. The DON said a head-to-toe assessment on Resident #1 and an emotional assessment were completed. The DON said the RP and MD were notified. The DON said a facility head count with emphasis on secured units was completed. The DON said an elopements drill was conducted on every shift (1st shift 6a-2p, 2nd shift 2p-10p, and 3rd shift 10p-6a), until all shifts were completed, and printed floor plans identifying the locations of all secured and alarmed doors were provided. The DON said in-services on the secured Exit Door, Elopement Prevention and Response, Secured unit and Safety Supervision of residents were completed.During an observation and interview on 5/12/2026 at 1:00 p.m., the ADM demonstrated functioning of the alarm systems on the secured locked door at the end of the hallway. The alarm systems were in working condition once the door was open with a combination keypad code. The ADM said he had changed the combination keypad code since the incident. He stated he currently did not have maintenance assistance, however on 05/07/2026, the Corporate Maintenance Technician came and checked all the door alarms at the facility. During an interview on 5/12/2026 at 1:35 p.m., the ADON said she had nothing further to add<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | except she was on staff at the time of the elopement and verified immediately the secured unit was searched and counted. The ADON said Resident #1 was not located on the unit, and the security door was locked. She said the staff were in-serviced on elopements drill every shift (1st shift 6a-2p, 2nd shift 2p-10p, and 3rd shift 10p-6a) until all shifts were completed. She said staff were further educated on Education stat on ANE, Elopement/Missing Resident, Elopement prevention and response, and Secured unit and Safety Supervision of residents.During an interview and observation on 5/13/2026 at 9:54 a.m., with Medical Records/CNA (B) said that on 4/30/2026 at approximately 9:49 a.m., she received a call from the police department regarding concerns of a missing resident. She said she immediately notified the DON, and she was instructed to identify the resident, and the team immediately proceeded to the memory care unit and the facility units. CNA (B) stated that at approximately 9:50 a.m., she identified Resident #1 standing on the sidewalk with a community neighbor in front of the neighbor's home. She stated police arrived approximately two minutes later. CNA (B) said she notified the DON that the individual was a resident of the facility. The ADM, DON, and MDS Nurse subsequently arrived at the scene by vehicle. According to CNA (B) the community neighbor reported he observed the resident standing in front of his yard and contacted police to determine whether the resident belonged to one of the nearby facilities. Following the interview, a walk-through was conducted to the location where Resident #1 was identified. Observation revealed the resident was found approximately one block from the facility and estimated seven-minute walk or 0.3 miles away, standing on the sidewalk along a local street with a posted speed limit of 30 mph in a college district.During an interview on 5/13/2026 at 12:30 p.m., with CN/LVN (K), CNA (C), and CNA (D), all three staff said they performed rounds every two hours to account for and verify the location of each resident on their unit. All three staff stated they had received in-service training regarding emergency codes, missing resident procedures, and conducting routine rounds to ensure residents were accounted for. Staff further stated they had been in-serviced not to provide facility security codes to non-employees, including family members, residents, or contract workers. During an interview on 5/13/2026 at 12:45 p.m. with CN/LVN (L), and CNA (E), both said they conducted rounds every two hours to account for residents and communicated resident locations, including appointments, dialysis and physical therapy. Staff stated they had received in-service training on elopement prevention alarms, missing resident procedures, and immediately accounting for residents. Staff further stated only employees should have access to security codes, and to ensure doors were closed securely. CNA (E) said staff were to assist visitors, residents, or contractors by entering door codes for them. During an interview on 5/13/2026 at 12:50 p.m., the DON said all staff, including nurses, dietary, housekeeping, and therapy staff, received in-served training on elopement prevention, missing resident response, secured door systems, and resident safety supervision. The DON said security door codes were not to be shared with residents, visitors or contractors, and staff were required to enter codes for individuals needed access to secured areas. The DON further stated elopement assessments were completed quarterly or with increased exit-seeking behaviors, elopement drills were conducted quarterly, and additional in-services were provided following elopement incidents.During an interview on 5/13/2026 at 4:30 p.m., with RN (M), CNA (F), and CNA (G), they said they performed rounds every two hours. CNA (F) said if a resident could not be located on the unit, staff searched the bathrooms and outside perimeters before notifying 911. All three staff stated security door codes were not to be shared with residents, visitors, family members or contractors, and staff were required to enter the code themselves when assisting individuals into the secured areas. Staff further stated they received in-service training on quarterly elopement drills and were required to follow up with the ADON or DON if they missed scheduled training. During an interview on 5/13/2026 at 4:50 p.m. with RN (N), CNA (H), and CNA(O) located on the secured unit, all three staff said they conducted rounds and resident head counts every two hours, and staff reported they had been in-serviced that the back secured door was not to be used for entrance or exit unless there was an emergency. Staff further stated the security door codes were not to be shared with<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | residents, family members, contractors, pharmacy staff, or delivery personnel. Staff stated they were responsible for assisting individuals needing access into the secured areas. Staff further stated they received monthly elopement training and or drills. Record review of facility Elopement Evaluation facility rating assessment Wandering and Elopements dated 3/2019 indicated Score value of 1 or higher indicated Risk of Elopement.Record reviews of electronic records indicated 19 residents located on the secured unit were assessed for elopement risk on 04/30/2026. Elopement risks were identified and updated, as necessary due to increased need for observation.Record review of care plans updated 5/13/2026 indicated 19 residents located on the secured unit were updated, as necessary with additional interventions related to elopement risk. Interventions included completing elopement risk assessments upon admission, readmission, quarterly, annually, with significant change, and as needed. Interventions also included informing the physician, responsible party, and residents of identified risk factors and any noted changes.Record review of facility Safety and Supervision of Residents Policy dated; Revision date July 2017, Med-pass 2001 indicated .2. Safety risk and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes: Quality Assurance and Performance Improvement reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. Systems Approach to Safety indicated .2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. Due to their complexity and scope, certain resident risk factors and environmental hazard are addressed. These risk factors included . e Unsafe Wandering.Record review of facility Routine Resident Checks Policy; Revision date July 2013, Med-pass 2001 indicated .2. Routine resident checks involve entering the resident's room and/ or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs, toileting assistance, etc. Review of facility Wandering and Elopements Policy; Revision March 2019, Med-pass 2001 indicated: Policy Statement: the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.3. Resident missing, initiate the elopement/missing resident emergency procedure; (a). Determine if the resident is out on authorized leave or pass; (b). initiate a search of the building(s) and premises; and (c). notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcements officials, and (as necessary) volunteer agencies. (rescue squads etc.).4. Resident returned to the facility DON or Charge nurse (a). examine the resident for injuries. (b). report finding and conditions of the resident. (e). complete and file an incident report, and (f). document relevant information. The facility took the following actions to correct the noncompliance prior to surveyor entrance:Record review of Resident #1's skin assessment completed by the DON, dated 4/30/2026 revealed no injuries noted.Record review of Resident #1's Head-to-toe assessment completed by the DON on 4/30/2026 revealed no injuries noted.Record review of Resident #1's Emotional assessment completed by the DON on 4/30/2026 revealed no signs and symptoms of emotional distress.Record review of Resident # 1's nurse's notes completed by the DON on 4/30/2026 revealed head-to-toe assessment was completed upon return to the secured unit at approximately 10:20 a.m. Skin was intact with no bruising, redness, or open areas noted. Resident denied pain, consumed 100% of snack and fluids, and was calm and cooperative. Resident remained alert and oriented x2 and currently on 1:1 observation due to elopement. Record review of facility's daily staffing assignments dated 4/30/2026 and 5/1/20206 indicated staff members' door duty assignments were scheduled for each shift, included first shift (6:00 a.m. to 2:00 p.m.), second shift (2:00 p.m. to 10:00 p.m.), and third shift (10:00 p.m. to 6:00 a.m.).Record review for Resident #1 revealed the responsible party and physician were appropriately notified of the incident that occurred on 4/30/2026. Documentation confirmed that notifications were completed on<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 4/30/2026 in accordance with facility policy. Record review of facility head count conducted on 4/30/2026 with emphasis on the secured unit, of the facility floor plan and resident roster dated 4/30/2026 revealed all 82 residents accounted for. Record review of the facility's elopement drills revealed drills were conducted for each shift (1st shift 6a-2p, 2nd shift 2p-10p, and 3rd shift 10p-6a) until all shifts were completed on 4/30/2026.Record review of the facility's Printed floor plans revealed they identified the locations of all secured and alarmed doors locations and were made available to staff. This information was incorporated into Frequent Rounding Training and education.Record review of the Logbook Documentation Emergency Preparedness Drills and Exercise revealed drills were conducted, elopement drill for missing Resident drill dated April 30th at 9:49am, April 30th at 4:15PM, April 30th at 10:20pm, May 2nd at 1:30pm, May 11 and May 12th, 2026.Record review of Door Locks and Alarm Checks dated 04/27/2026 to 05/1/2026, 5/11/2026 and 5/12/2026 revealed all doors, locks and alarms had been tested frequently since 04/30/2026Record review of the Quality Assessment and Performance Improvement (QAPI) Plan meeting revealed the meeting was conducted on 4/30/2026 at 3:43p.m. and attended by all required staff in accordance with Quality Assessment and Performance improvement regulatory guidelines.Record reviews of electronic records revealed all 19 residents located on the secured unit were assessed for elopement risk on 04/30/2026. Elopement risks were identified and updated, due to increased need for observation. Interventions included completing elopement risk assessments upon admission, readmission, quarterly, annually, with significant change, and as needed. Record review of care plans updated 5/13/2026 revealed 19 residents located on the secured unit were updated, as necessary with additional interventions related to elopement risk. Interventions included completing elopement risk assessments upon admission, readmission, quarterly, annually, with significant change, and as needed. Interventions also included informing the physician, responsible party, and residents of identified risk factors and any noted changes. Record review of the facility's local company billing information dated 05/06/2026 revealed that a back emergency exit (a commercial-grade device) was installed with an HD SM ([NAME]-Duty Surface Mounted) door closer. Record review of documentation of training of all staff conducted beginning 04/30/2026 after the elopement for Elopement Prevention, Elopement Response, Abuse and Neglect:Record review of in-service on Entrance and Exit codes dated 4/30/2026 indicated Do not give codes out to non-employees such as Family Member, the residents, and contracted workers. Assist with helping individuals in an out of building. The training was conducted by the DON.Record review of in-service on Education stat on ANE and Elopement/Missing Resident dated 4/30/2026 indicated to assure that all residents were properly attended to and appropriately monitored.Record review of in-service on Elopement risk dated 4/30/2026 indicated all residents in the secured unit were elopement risk residents. The training was conducted by the DON.Record review of in-service on Elopement, Prevention and Response dated 4/30/2026 indicated the need to ensure all staff prevented elopement through active supervision and environmental awareness. Recognize high-risk residents. Respond immediately and correctly, if a resident attempted to leave or goes missing. The training was conducted by the DON.Record reviewed of in-service on Frequent Rounding dated 04/30/2026 indicated staffs conducted Rounds on Residents every two hours. Nurses (even hour) and CNAs were (odd hour). The training was conducted by the DON.Record review of in-service on Secured Unit and Safety Supervision of residents 4/30/2026 indicated staff to make frequent rounds to ensure all residents are accounted for. Make sure doors are secured and alarm is set. The training was conducted by the DON.Record review of in-service on Abuse and Neglect dated 4/30/2026 indicated ensured that all residents are being properly attended to and were being monitored. The training was conducted by the DON.Record review of in-service on Abuse Neglect Exploitation and Misappropriation Prevention Program dated 4/30/2026 indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Which included but not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical<br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | restraint not required to treat the resident's symptoms. Record review of in-service on Frequent Rounding dated 4/30/2026 indicated Make frequent rounds to ensure all residents are accounted for. Make sure doors are secured and alarm is set. The training was conducted by the DON.Record review of in-service record door post Exit Door (DO NOT USE THE Back DOOR ON THE SECURE UNIT! THAT DOOR IS NOT AN ENTRANCE OR EXIT) Disciplinary action will be taken. The Secure unit is not a cut through, walk around. 4/30/2026. The training was conducted by the DON. |