STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Health Service Regulation, Nursing Home Licensure and Certification Section, conducted a complaint investigation from 07/26/12 through 07/28/12, and 07/30/12 through 07/31/12. Immediate Jeopardy began in 483.25 on 07/22/12. It was removed on 07/28/12 when the facility provided and implemented an acceptable credible allegation of compliance.	F 000	**On 07/22/12 at 11:36 am Resident #2 was found by a visitor at the grassy area near the facility's front entrance of the facility property. On 7/22/12 at 11:45 am Resident #2 was brought back into the facility by nursing staff and was assessed by a Registered Nurse to have no physical injuries. Resident #2's wanderguard was checked by the Registered Nurse (RN) Supervisor and was found to not lock/work properly by failing to alarm or lock the facility's front door. Resident #2 was immediately placed on 1:1 direct supervision with a staff member. On 7/22/2012 at 3:15pm Resident #2 was transported to Emergency Room for evaluation related to being found outside and at 8:30pm he was returned to the facility with no new orders. On 07/22/12 at approximately 8:45pm a functioning wanderguard bracelet that was tested by Administrator and Regional Registered Nurse and applied to Resident #2's left ankle and wheel chair of resident. On 07/22/12 Resident #2 was reassessed for wandering/exit seeking behaviors and his care plan was updated by Regional Registered Nurse for 1:1 direct supervision. As of 07/28/12 Resident #2 remains on direct 1:1 supervision with staff.**	8/9/2012
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, vendor and staff interviews, the facility failed to prevent one (1) of twenty two (22) sampled cognitively impaired residents, who were assessed as being at risk for elopement, from exiting the facility. Resident #2 left the facility unsupervised on 07/22/12 and was found by visitors and staff near the main road approximately 150 feet away from the facility entrance door (Resident #2). Immediate Jeopardy began on 7/22/12 when Resident #2 left the facility unsupervised and was found by visitors near the main road sustaining head contusion and abrasion. The resident's Wanderguard bracelet failed to activate the lock	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B.C. | TITLE: Administrator | (X6) DATE: 8-15-12

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.

Original Signature Date: 8-9-12

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F 323	Continued From page 1 and alarm system on the door. Immediate Jeopardy was identified on 7/27/12 at 2:07PM and was removed on 7/28/12 at 4:57PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. The findings are: Resident #2 was admitted 8/24/2010 with diagnoses of severe hypoxic-ischemic encephalopathy, spasm of muscles, abnormal involuntary movement and dementia with behavioral disturbance. A quarterly minimum data set (MDS) assessment dated 5/8/12 coded Resident #2 with severe cognitive impairment and independent with wheelchair mobility. A nursing neurological assessment dated 5/8/12 documented that Resident #2 had wandering behavior that occurred daily. A plan of care revised 6/11/12 for elopement risk due to cognitive loss had a goal that resident would not leave the building without an escort. Interventions included: in the event of elopement follow search and reporting protocols; redirect the resident when security system sounds and/or resident attempts to leave the building and utilize and monitor security bracelet per protocol. Review of the physician order revealed an original	F 323	**On 7/22/12 at approximately 1:00 pm twenty-two (22) residents with wanderguard signaling devices were transported to the facility's front door to determine if their wanderguard bracelets were functioning properly. All wanderguard devices were observed to function properly by the facility's RN Supervisor and Regional Registered Nurse. Again on 7/22/2012 at approximately 6:00 pm all residents with signaling devices were transported to the facility's front door and side door for test of function. All devices were again functioning properly. Beginning on 7/23/2012 at 7:00 am all doors with the wanderguard alarming system were monitored 24 hours/day by a staff member and the facility will continue to do so for 30 days and then re-evaluate at the monthly QIC meeting. Effective 8/2/2012, a random selection of 5 residents will be taken daily to all doors with wanderguard system to ensure the system is working properly. The remainder of the residents will have a device check per calibrated wanderguard testing device every day to ensure system is working properly. Continuing monitoring of the functioning of residents with wanderguard bracelets will be documented on "Wandering customer monitoring system" form will be ongoing. On 7/23/2012 the facility ordered twenty-five (25) new wanderguard bracelets and two (2) calibrated wanderguard testing devices. On 07/28/12 the facility obtained two (2) new calibrated wanderguard testing devices and twenty-five (25) new wanderguard bracelets.**	

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F 323	Continued From page 2 order dated 1/23/11 for a wanderguard bracelet. A nursing note written by licensed nurse (LN) #1 dated 7/22/12 at 11:15AM revealed that Resident #2 followed nursing assistant (NA) #1 through the kitchen double doors (service doors) and the Wanderguard system did not alarm. NA #1 returned him to the nurse's station and made the nurse aware. An interview with LN #1 on 7/26/12 at 3:00PM revealed that she was Resident #2's nurse on 7/22/12. She explained that Resident #2 frequently wandered and utilized a Wanderguard bracelet. At 11:00AM, Resident #2 followed NA #1 through the service doors down the service hallway and his Wanderguard bracelet (1) did not cause the doors to alarm. She continued to explain that another employee observed the resident to be on the service hallway and brought it to the attention of the NA. The NA then immediately brought Resident #2 back to the nurse's station and LN#1 was made aware that the resident's Wanderguard (1) did not work at approximately 11:15AM. At that time LN #1 removed the resident's Wanderguard (1) and placed it at the nurse's station and then applied Wanderguard (2) to the resident's ankle. She further added that she activated the Wanderguard before placing it on Resident #2's ankle but did not check the Wanderguard with the signaling device tester because that was done on 3rd shift. At around 11:25AM she left Resident #2 at the nurse's station and continued with her duties. At 11:36AM she was called to the front by NA #2 who was returning from lunch and stated that Resident #2 was near the road at the front of the facility property.	F 323	**On 7/23/2012 education was initiated by Administrator and Regional Registered Nurse for all nursing staff on the activation of the wanderguard system and physical testing of bracelet at the doors. On 07/23/12 education by the Director of Nursing/Nurse Managers initiated for all nursing staff on the elopement/wanderguard system to include; training to check the activation date, expiration date (ninetieth (90) day from activation) of wanderguard bracelets, and to test the wanderguard bracelets to ensure proper functioning by utilizing a calibrated wanderguard tester before applying the bracelet to a resident. Staff was directed to check resident Wanderguard bracelets every shift for placement and proper functioning according to manufacturer's recommendations. If there is a malfunction of wanderguard system, resident(s) will immediately be placed on 1:1 direct supervision until system is working properly. No nursing staff will be allowed to work until they have received this inservice training. On 7/24/2012 a form was developed to monitor accurate functioning of door alarm system that is to be utilized by staff. On 7/27/2012 all maintenance staff was educated on the manufacturer's specifications for the use and the maintenance of the wanderguard system. ~~Effective 8/1/2012~~ this education will be implemented into the new employee orientation program for all new employees.** PER ADM. 08/16/12 TSD	

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F 323	Continued From page 3 An incident report for Resident #2 dated 7/22/12 stated assigned staff reported that the resident was found in a grassy area between the parking lot and the road at the front of the facility property with wheelchair overturned. Resident #2 was placed in his wheelchair and brought back into the facility and he reported he was going to the store. The nursing note written by LN #1 dated 7/22/12 at 11:45AM stated resident had no apparent injury noted at this time, range of motion was appropriate and he denied pain. Neurological checks were initiated due to the un-witnessed fall and 1:1 staff supervision was initiated. An interview with NA #2 on 7/26/12 at 3:20 PM revealed upon return from lunch (on 7/22/12), as he was driving into the facility entrance off the main road, he observed a vehicle at the entrance and a group of people surrounding a tree at the front of the property. He exited his vehicle at approximately 11:35AM and observed a resident to be at the tree surrounded by the visitors. He explained that the visitors told him they found Resident #2 lying in the "ditch" (drainage ditch) with his wheelchair turned over. They continued to explain to him that they assisted the resident back into his wheelchair and wheeled him under the tree. NA #2 stated that he observed Resident #2 for any visual injury and then at 11:36 AM called the nurse to notify her that Resident #2 was outside and observed the corporate nurse (CN) to be walking toward the scene. NA# 2 stated that at 11:38AM he and the CN escorted Resident #2 back into the building and the front entrance doors did not alarm. An observation of the front of the facility property	F 323	**All three (3) facility doors with the wanderguard alarming system will be checked every day by Maintenance Department/Manager on Duty for proper functioning of wanderguard system by Maintenance Director or designee. Findings will be documented on Daily Door check forms. If any issues are identified with an exit door that is equipped with a wanderguard not functioning properly a staff member will be posted at the door and the issue will be immediately reported to Administrator. Maintenance Director will also call wanderguard system's Technical Support for direction on any issues. Maintenance Director/Designee will check calibrated testing devices for accurate functioning per manufacturer's recommendation monthly. The Director of Nursing/designee will monitor the wandering customer monitoring system tool daily for 30 days and then weekly for 30 days to ensure compliance with corrective action taken as needed. All trends will be taken to the monthly QA committee for continued quality improvement.**	

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F 323	Continued From page 4 was made on 7/26/12 at 3:35PM. The facility entrance was adjoined to a two lane road. A drainage ditch was observed approximately 10-15 inches from the road to the right of the facility's property sign and was approximately 4 feet (ft) deep. The tree (identified by NA #2 as the location of Resident #2 when he returned from lunch) was observed approximately 10 ft from the drainage ditch and 15 ft from the road. A telephone interview with the CN on 7/26/12 at 4:15PM revealed that on 7/22/12 a visitor entered the building and notified her that a resident was outside by the road. She stated that as she walked across the parking lot she noted NA #2, and several visitors surrounding Resident #2 by the tree at the front of the property. She stated that when she arrived the visitors left and she observed Resident #2 to be in his wheelchair with no obvious injury. She then accompanied Resident #2 and the NA back to the building where LN #1 was waiting. She stated that as she entered the facility with the resident the entrance doors did not alarm. An interview with LN #1 on 7/26/12 at 4:20PM revealed that on 7/22/12 at 11:45 M when Resident #2 was wheeled back into the facility after being found at the front of the facility property, his Wanderguard bracelet (2) did not cause the front entrance door to alarm. LN #1 explained that when Resident #2 was wheeled back into the building she returned him to the unit and assessed him to be without injury and he verbalized no complaint of pain. The LN further explained that at this point the CN instructed that 1:1 supervision be instituted for Resident #2. LN #1 stated that she took Wanderguard (1) from the	F 323		

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F 323	Continued From page 5 nurse's station (which had been removed at 11:15AM, but not discarded) and brought it to the front doors, and the doors alarmed and locked. At approximately 12:00 PM she attached Wanderguard (1) to the back of Resident #2's wheelchair and did not remove Wanderguard (2) from his ankle or replace Wanderguard (2) with a new device. She continued to explain that she wheeled Resident #2 to the front entrance door and the service doors and Wanderguards (1) and (2) did not alarm or lock the doors. LN #1 stated she did not remove Wanderguard (1) or Wanderguard (2) because she felt there had to be a problem with the doors. She further added that Resident #2 was sent out to the emergency room on 7/22/12 at 3:15 PM for further evaluation related to elopement. Review of the Emergency Department (ED) visit summary dated 7/22/12 documented diagnoses of head injury- contusion and abrasion. A computed tomography (CT) of the head was done and revealed no acute intracranial abnormality. An interview with the Administrator on 7/27/12 at 11:05AM revealed that on 7/22/12 when Resident #2 returned from the ER at 8:45PM and entered through the front doors, the doors did not alarm. The Administrator further explained that he took Resident #2 to the service doors and the service doors did not alarm. At this point the Administrator removed Resident #2's Wanderguards (1) and (2), activated Wanderguards (3) and (4) without testing them with the signaling device tester and then placed Wanderguard (3) on the resident's right ankle and Wanderguard (4) to the resident's wheelchair.	F 323		

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F 323	Continued From page 6 The Administrator stated he did not notify the unit nurse of the Wanderguards being changed and he did not document on the wandering customer sheet and was unaware of what the "activate by" dates were on Wanderguards (3) and (4). On 7/26/12 at 1:25PM the Administrator was interviewed and stated that the facility followed the manufacturer's user manual for the use of their Wanderguard system. A review of an undated manufacturer's user manual for the Wanderguard electronic monitoring system revealed the following: The system consisted of antenna modules installed on an exterior door which would alarm and lock the door whenever any resident wearing a signaling device (Wanderguard bracelet) approached the door. The manual noted that a stamped date on each bracelet indicated the last day the bracelet could be activated which would permit approximately 90 days of use. The manual read in part: "Record the activation date and the 90th day from the activation date on the resident's chart to ensure the signaling device is replaced promptly." The user manual also noted that each signaling device should be tested before being put into use and daily thereafter and each antenna module on the door should be tested at least weekly on each shift. An interview with the Director of Nursing (DON) on 7/26/12 at 2:55PM revealed that the facility utilized a wandering customer monitoring sheet for documentation of Wanderguard device presence and proper functioning. She explained that all shifts were responsible for documenting the presence of the Wanderguard and that third	F 323		

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F 323	Continued From page 7 shift would check for proper functioning. She also stated that the nurses were to document the day that the Wanderguards were applied and activated on the wandering customer monitoring sheet. Review of Resident #2's wandering customer monitoring sheets from January 2012 until July 2012 revealed that the only documentation of his Wanderguard bracelet being replaced was on 7/22/12 by LN#1 and there was no documentation of the 90th day after activation date. Interview with the DON on 7/27/12 at 11:20AM revealed that she was not aware that the manufacturer recommended recording the 90th day from activation date of the Wanderguard bracelet to ensure that the bracelets were replaced promptly. She also added that her nurses would not know when the 90th day from activation date was as the wandering customer monitoring system sheet could be thinned or removed from the active chart. An interview with LN #2 on 7/27/12 at 10:50AM revealed that she was not aware that the Wanderguard bracelet would only function properly for 90 days after activation. LN # 2 further added that she was only trained to document the placement date. An interview with LN #1 on 7/28/12 at 10:20AM revealed that she was not aware that the 90th day from activation date was to be documented. LN #1 stated she would only document the date that the Wanderguard was placed on the resident. Observation of Resident #2 in the business office	F 323		

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F 323	Continued From page 8 on 7/27/12 at 11:00AM revealed Resident #2 with Wanderguard (4) attached to the back right of his wheelchair with an activate by date of 10/30/12 and a Wanderguard (3) to his right ankle with an activate by date of 5/5/12. On 7/28/12 at 2:00PM the Administrator was asked if he was aware of Resident #2's Wanderguard (3) having an expired activate by date of 5/5/12. He stated that Wanderguard (3) worked and was tested at the front door and service doors. A telephone interview with a technical support person for Wanderguard on 7/27/12 at 5:47PM revealed that a Wanderguard bracelet activated on 7/22/12 with an activate by date of 5/5/12 would not be guaranteed to function. A telephone interview with the Senior Technical Advisor for the Wanderguard Company on 7/27/12 at 12:56PM revealed that the company recommended that the signaling device (Wanderguard bracelet) be replaced 90 days from activation. He explained that the device contained a memory chip that signaled the Wanderguard alarm system to sound and lock and that the memory chip would no longer function 90 days from activation. He also stated that the stamped date on the signaling device is the date it should be activated by. He further explained that the signaling device tester read the battery life of the Wanderguard bracelet and not the functioning of the memory chip. Therefore, the battery could be functional (causing a green light on the tester) but the memory chip deactivated, which would cause the Wanderguard alarm system not to lock or alarm when a	F 323		

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F 323	Continued From page 9 Wanderguard bracelet was within range. He also added that the doors with a Wanderguard alarm system must be checked weekly to ensure proper functioning. An interview with the Administrator on 7/26/12 at 1:25PM revealed that the doors had been checked on 7/24/12 and they were functioning properly and that he thought the problem was with the Wanderguard bracelets that Resident #2 was wearing; they just did not cause the doors to alarm. A review of the Facility Wanderguard service visit dated 7/24/12 revealed that the front door required a control unit (a box which relayed the signal received from the Wanderguard antennas to the door to initiate the doors to lock) to be replaced. The back door was checked to make sure it was functioning properly and some tuning was done. All doors appeared to be working to specification. An interview with the Director of Customer Relations for Wanderguard regarding the 7/24/12 service visit was conducted on 7/30/12 at 7:25PM. She revealed that the control unit was replaced on the front door because the technician found the door to lock and unlock intermittently without requiring a signal from the Wanderguard bracelet. She further added that there was a possibility that the front doors would have unlocked even if a resident had a Wanderguard bracelet in place. She also explained that the service door had a "fried buzzer" which would have affected the doors ability to alarm when opened.	F 323		

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F 323	Continued From page 10 Observation of the facility doors on 7/27/12 at 9:40 AM revealed three (3) doors were equipped with Wanderguard systems. Review of the facility's monitoring log for doors which had a resident Wandering system revealed that the doors with Wanderguard alarm systems were last checked on 6/30/12 and were functioning properly at that time. The log also revealed that the doors were only being checked once per month. An interview with the Maintenance Director on 7/27/12 at 9:50 AM revealed that the Wanderguard system at every door was tested monthly and that he was not aware that the manufacturer's user manual recommended the doors to be tested weekly. The Administrator was notified of the Immediate Jeopardy on 7/27/2012 at 2:07 PM. The facility provided a credible allegation of compliance on 7/28/2012 at 4:57 PM. The allegation of compliance indicated: Credible Allegation of Compliance: 1. On 07/22/12 at 11:36 am Resident #2 was found by a visitor at the grassy area near the facility's front entrance of the facility property. On 7/22/12 at 11:45 am Resident #2 was brought back into the facility by nursing staff and was assessed by a Registered Nurse to have no physical injuries. Resident #2's Wanderguard was checked by the Registered Nurse (RN) Supervisor and was found to not lock/work	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 properly by failing to alarm or lock the facility's front door. Resident #2 was immediately placed on 1:1 direct supervision with a staff member. On 7/22/12 at 3:15pm Resident #2 was transported to the Emergency Room for evaluation related to being found outside and at 8:30pm he was returned to the facility with no new orders. On 07/22/12 at approximately 8:45pm a functioning Wanderguard bracelet that was tested by the Administrator and Regional Registered Nurse and applied to Resident #2's left ankle and wheel chair of resident. On 07/22/12 Resident #2 was reassessed for wandering/exit seeking behaviors and his care plan was updated by the Regional Registered Nurse for 1:1 direct supervision. As of 07/28/12 Resident #2 remains on direct 1:1 supervision with staff. 2. On 7/22/12 at approximately 1:00 pm twenty-two (22) residents with Wanderguard signaling devices were transported to the facility's front door to determine if their Wanderguard bracelets were functioning properly. All Wanderguard devices were observed to function properly by the facility's RN Supervisor and Regional Registered Nurse. Again on 7/22/2012 at approximately 6:00 pm all residents with signaling devices were transported to the facility's front door and side door for test of function. All devices were again functioning properly. Beginning on 7/23/2012 at 7:00 am all doors with the Wanderguard alarming system were monitored 24 hours/day by a staff member and the facility will continue to do so until 8/03/2012 if all Wanderguard monitors are functioning properly. Continuing monitoring of the functioning of residents with Wanderguard bracelets will be documented on "Wandering customer monitoring	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 07/31/2012

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F 323	Continued From page 12 system" form will be ongoing. Effective 7/28/2012, all residents will be taken daily to all doors with Wanderguard system to ensure the system is working properly. 3. On 7/23/2012 the facility ordered twenty-five (25) new Wanderguard bracelets and two (2) calibrated Wanderguard testing devices. On 07/28/12 the facility obtained two (2) new calibrated Wanderguard testing devices and twenty-five (25) new Wanderguard bracelets. 4. On 7/23/2012 education was initiated by Administrator and Regional Registered Nurse for all nursing staff on the activation of the Wanderguard system and physical testing of bracelet at the doors. On 07/23/12 education by the Director of Nursing/Nurse Managers initiated for all nursing staff on the elopement/Wanderguard system to include; training to check the activation date, expiration date (ninetieth (90) day from activation) of Wanderguard bracelets, and to test the Wanderguard bracelets to ensure proper functioning by utilizing a calibrated Wanderguard tester before applying the bracelet to a resident. Staff was directed to check resident Wanderguard bracelets every shift for placement and proper functioning according to manufacturer's recommendations. If there is a malfunction of Wanderguard system, resident(s) will immediately be placed on 1:1 direct supervision until system is working properly. No nursing staff will be allowed to work until they have received this in-service training. On 7/24/2012 a form was developed to monitor accurate functioning of door alarm system that is to be utilized by staff. On 7/27/2012 all	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 13 maintenance staff was educated on the manufacturer's specifications for the use and the maintenance of the Wanderguard system. 5. All three (3) facility doors with the Wanderguard alarming system will be checked every day by Maintenance Department/Manager on Duty for proper functioning of Wanderguard system by Maintenance Director or designee. Findings will be documented on Daily Door check forms. If any issues are identified with an exit door that is equipped with a Wanderguard not functioning properly a staff member will be posted at the door and the issue will be immediately reported to Administrator. Maintenance Director will also call Wanderguard system's Technical Support for direction on any issues. 6. The Director of Nursing/designee will monitor the wandering customer monitoring system tool daily for 30 days and then weekly for 30 days to ensure compliance with corrective action taken as needed. All trends will be taken to the monthly QA committee for continued quality improvement. The credible allegation was verified 7/28/2012 at 5:00PM as evidenced by staff interviews on the use of the wandering customer monitoring tools, when Wanderguards are to be replaced; how often testers would be calibrated or replaced, how often Wanderguard sensor doors would be checked for accuracy of alarming and what should be done if the doors failed to alarm or the Wanderguard bracelets failed to function.	F 323		