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	345181	A. BUILDING _____ B. WING _____	C 03/11/2022

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UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST FIFTH STREET GREENVILLE, NC 27834

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 3/11/2022. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 14XJ11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 3/11/2022. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 3 of the 6 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and family interviews the facility failed to keep a resident ' s heart monitor for a pacemaker plugged in and charged for 1 of 3 residents reviewed for professional standards of care. (Resident #1) Findings included: Resident #1 was admitted to the facility on	F 658	Immediate correction was achieved for the alleged deficient practice: on 3/7 the heart monitor belonging to resident #1 was located and plugged in to resume charging. The facility Director of Nursing confirmed its placement and proper functioning on this date. The facility recognizes that all residents who have an external monitoring device have the potential to be affected by the	3/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/25/2022

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F 658	Continued From page 1 12/1/21. His active diagnoses included dysarthria and anarthria, tachycardia, atrioventricular block, and presence of cardiac pacemaker. A review of Resident #1 ' s quarterly minimum data set assessment dated 2/26/22 revealed he was assessed as severely cognitively impaired. A review of Resident #1 ' s care plan dated 2/26/22 revealed he was care planned for a pacemaker related to a diagnosis of atrioventricular block. The interventions included to observe for signs and symptoms of pacemaker failure, vital signs per facility protocol and as needed, keep resident a few feet away from electromagnetic interferences, and perform pacemaker check as ordered. A review of Resident #1 ' s orders and medication administrator record revealed there was no documentation of Resident #1 having a heart monitor for his pacemaker. A review of the manufacturer ' s manual dated 3/20/20 for Resident #1 ' s heart monitor revealed the monitor was intended primarily for continuous operation at home. The monitor was documented as not an emergency system. If the heart monitor was powered off for an extended period of time, data may be lost. If the monitor was to be used in mobile operation, it was recommended the device be charged every night on the bedside table. The manual indicated the installed batter would supply the monitor 16 hours of power. Resident #1 ' s nursing note dated 2/23/22 revealed Residents #1 ' s family requested the nurse ensure Resident #1 ' s heart monitor for his pacemaker be kept charged and near him.	F 658	alleged deficient practice. 100% audit of facility residents was conducted on 3/22 and it was determined that no other resident had an external monitoring device outside of resident #1. Systemic changes implemented to ensure the alleged deficient practice does not reoccur: 100% of licensed nursing staff will be provided in-service education regarding the necessity of ensuring external monitoring devices, such as the heart monitor are checked routinely for proper functioning and operation. This education will be provided by the facility Director of Nursing or designee and will be completed by 3/25/22. licensed staff will receive the education prior to being allowed to begin working. All identified external monitoring devices will be placed on the Medication Administration Record and will require the nurse to check the device each shift for operation and proper placement. Monitoring to ensure that the alleged deficient practice does not reoccur starting on 3/28, the facility Director of Nursing/Interdisciplinary Team will check new admissions during the clinical meeting, Monday thru Friday to validate if the resident has an external monitoring device and if present will ensure the orders to monitor are on the Medication Administration Record. In addition, the facility Director of Nursing, or designee will audit Medication Administration Records to ensure nursing staff have been monitoring devices appropriately as well as verify each device is in good operation and proper placement. This	

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F 658	Continued From page 2 During an interview on 3/7/22 at 9:25 AM Resident #1 ' s family member stated they continually found Resident #1 ' s heart monitor unplugged and under his bed or behind his nightstand when they visited the facility. During observation with Nurse #1 on 3/7/22 at 9:40 AM Resident #1 ' s heart monitor was observed under the resident ' s bed, unplugged, and was powered off. During an interview on 3/7/22 at 9:59 AM Nurse #1 stated she was not aware Resident #1 had a heart monitor and it was not plugged in. She further stated the heart monitor was not in the orders and this was why she was not aware he had one. Upon attempting to turn the device on, she stated the battery was completely dead and the device should have been plugged in. She concluded it must have been unplugged for some time as the battery was completely dead. During an interview on 3/7/22 at 10:30 AM the Director of Nursing stated Resident #1 ' s heart monitor should have been plugged into the wall outlet. She further stated due to the batter being dead, the monitor must have been unplugged for some time. The Director of Nursing stated there was no order in the chart for checking the heart monitor, there should have been, and she would get a new order as soon as possible. The heart monitor was not new coming from the hospital and the family brought it in as it was an old heart monitor. She concluded when the family brought the device in, the nurse must not have gotten an order for checking the heart monitor which was why the nurse was not aware of the monitor.	F 658	monitoring will be recorded on the Monitoring device Quality Improvement tool and to be completed daily, Monday through Friday x5 day; weekly x4 weeks; then monthly x 2 months. The Director of Nursing will present the results of the audits to the facility's Quality Assurance and Performance Improvement Committee during their meetings for 3 months or until a pattern of substantial compliance is achieved.	

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F 658	Continued From page 3 During an interview on 3/7/22 at 1:17 PM Cardiologist Nurse #1 stated Resident #1 had a cardiac pacemaker and monitor. The monitoring device was to be left on and plugged in to the wall at the nightstand to transmit data to their office. She further stated if a resident ' s monitor did not transmit data for 14 days, they would receive a notification by an automatic system, and this had not happened with Resident #1 so the device could not have been off for 14 days or more. She concluded the risk of having the monitor unplugged and the battery being dead was that the data would miss rhythm abnormalities or issues with device during that time, but the devices was simply a recording device and not a life saving device. During an interview on 3/7/22 at 3:26 PM Nurse #2 stated he was Resident #1 ' s nurse on 3/6/22. He stated he was aware Resident #1 had a heart monitor and had found the monitor unplugged at times and had not noted if the battery was dead or not. He concluded he did not remember observing Resident #1 ' s heart monitor on 3/6/22. During an interview on 3/8/22 at 8:06 AM the Administrator stated he was unable to identify which staff member received the heart monitor from the family.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		3/25/22

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F 690	Continued From page 4 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interviews the facility failed to monitor and act on a change of a resident ' s urine opacity and color for 1 of 1 resident reviewed for catheter care. (Resident #1) Findings included:	F 690	Immediate correction was achieved for the alleged deficient practice: Urinary catheter for Resident 1 was assessed by facility Director of Nursing on 3/8. The catheter was changed, and urinalysis was obtained on 3/8. The facility recognizes that all residents who have an foley catheter have the	

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F 690	Continued From page 5 Resident #1 was admitted to the facility on 12/1/21. His active diagnoses included Parkinson ' s disease, dementia with Lewy bodies, cognitive communication deficit, benign prostatic hyperplasia (enlarged prostate) without lower urinary tract symptoms, and retention of urine. A review of Resident #1 ' s records revealed Resident #1 had UTIs on12/1/22 present upon admission, 12/21/22, and 1/28/22. A review of Resident #1 ' s quarterly minimum data set assessment dated 2/26/22 revealed he was assessed as severely cognitively impaired. He had no moods or behaviors. He required extensive assistance with bed mobility and was totally dependent on staff for transfers, locomotion on and off unit, dressing, eating, toilet use, and personal hygiene. He had a urinary catheter and was always incontinent of bowel. A review of Resident #1 ' s care plan dated 2/26/22 revealed he was care planned for the use of a urinary catheter. The interventions included to secure catheter tubing to thigh to prevent pulling, assess for acute behavioral changes that may indicate Urinary Tract Infections (UTIs), encourage fluid intake during waking hours, change catheter tubing/bag as specified, catheter care every shift, keep the drainage bag below the level of the bladder, provide peri care away from scrotum to minimize bacterial migration into urethra and bladder, keep catheter tubing patent to avoid obstruction of urine outflow, ensure catheter tubing is secured, free of kinks or twisting to avoid urethral tension or accidental removal, observe for leakage around the catheter and report to license nurse as appropriate, and observe for skin irritation and excoriation and	F 690	potential to be affected by the alleged deficient practice. On 3/8 the DON completed a 100% audit on all resident that have foley catheters to ensure the urine did not show any signs of complications and did not require any additional services. No other catheter required servicing at that time. Systemic changes implemented to ensure the alleged deficient practice does not reoccur: As of 3/25 100% of the facility's nursing staff was provided in-service education by the facility Director of Nursing or designee regarding the requirement that all residents with catheters must be checked each shift to ensure that the urine is flowing and to determine if there are any complications/changes in the urine. When abnormalities are noted, this must be communicated to the nurse in order to for the resident to be assessed and changes are addressed. Orders will be obtained for all residents with catheters to be checked each shift and the nurse will document this on the Medication Administration Record. Monitoring to ensure that the alleged deficient practice does not re-occur starting on 3/28, the facility Director of Nursing, or designee will audit Medication Administration Records to ensure nursing staff have been monitoring Catheters appropriately as well as verify each that there are no unaddressed changes. This monitoring will be recorded on the Catheter care Quality Improvement tool and to be completed daily, Monday through Friday x5 day; weekly x4 weeks;	

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F 690	Continued From page 6 report to licensed nurse as appropriate. A review of Resident #1 ' s nursing note dated 3/4/22 at 11:45 AM completed by Nurse #2 revealed Resident #1 ' s catheter was in place and urine was flowing. The urine was documented as clear and yellow. There were no further nursing notes for Resident #1 regarding his urine. During an interview on 3/7/22 at 9:25 AM Resident #1 ' s family member stated they continually had concerns with Resident #1 ' s urine. He further stated Resident #1 ' s urine would become cloudy and the resident would complain of pain to his stomach but the staff would not act upon their concerns for multiple days and would not assess his urine color and status on a regular basis. During observation on 3/7/22 at 9:40 AM Resident #1 ' s urine was observed in his catheter tubing. The urine was amber, cloudy, and opaque. Amber debris was observed in the urinary catheter filter. During an interview on 3/7/22 at 9:59 AM Nurse #1 stated she was Resident #1 ' s nurse. She further stated to her knowledge Resident #1 did not have any current urinary tract infections (UTIs). She further stated no staff had reported to her any concerns with Resident #1 ' s urine. Upon observing the resident ' s urine, she stated the tubing needed to be changed and the urine was cloudy and amber in color. The nurse stated she had not yet observed Resident #1 ' s urine. Nurse #1 concluded she should have been notified of the resident ' s urine as in her experience, based	F 690	then monthly x 2 months. The results from these audits will be presented to the facility's Quality Assurance and Performance Improvement Committee meetings for 3 months or until a pattern of substantial compliance is achieved.	

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F 690	Continued From page 7	F 690		

on the debris and appearance of the urine, it did not occur "overnight."

During an interview on 3/7/22 at 10:17 AM Nurse Aide #1 stated she had emptied Resident #1 ' s catheter and provided catheter care that morning during his morning care. She stated the urine was amber and cloudy and nurse aides were to report any changes in urine to the nurse. She concluded she had not notified the nurse of any concerns with Resident #1 ' s urine.

During an interview on 3/7/22 at 10:30 AM the Director of Nursing stated the urine was very opaque, cloudy, and amber with debris in the filter indicating the urine had this appearance for some time and should have been brought to the attention of the nurse and physician prior to today. She further stated there was no documentation of any concerns with Resident #1 ' s urine since 3/4/22 when it was documented as yellow and clear and no documentation of the nurses requesting a urinalysis or flushing the catheter.

During an interview on 3/7/22 at 1:11 PM Nurse Aide #2 stated she worked with Resident #1 on 3/6/22 during the 7 AM to 3 PM shift. She stated she did notice his urine was reddish and different from normal and notified Nurse #2 about the concern.

During an interview on 3/7/22 at 3:26 PM Nurse #2 stated he was Resident #1 ' s nurse on 3/6/22. He stated he did not remember observing Resident #1 ' s urine status in the resident ' s urinary catheter and Nurse Aide #2 did not notify him of any concerns with Resident #1 ' s urine during that shift and he did not notify the

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F 690	Continued From page 8 physician of any concerns with Resident #1 ' s urine as a result.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to secure medication carts when left unattended for 2 of 3 medication carts observed (200 Hall Medication Cart and 500 Hall Medication Cart).	F 761	Immediate correction was achieved for the alleged deficient practice: the medication carts belonging to the 200 and 500 halls were secured on 3/8 by facility staff by locking them. Nurse #3 and nurse #4 received individual in-service education	3/25/22

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F 761	Continued From page 9 Findings included: 1. During observation on 3/8/22 at 7:50 AM the 200 hall medication cart was observed unlocked and unattended on the 700 hall. At 7:51 AM two staff members walked past the medication cart. At 7:52 AM Nurse #3 returned to the unlocked medication cart from a resident ' s room. During an interview on 3/8/22 at 7:52 AM Nurse #3 stated medication carts were to be locked when left unattended. He concluded when he left the cart and entered the resident ' s room where he could not see the cart, he should have locked the medication cart and did not. During an interview on 3/9/22 at 1:31 PM the Director of Nursing stated medication carts should be locked when unattended. 2. During observation on 3/9/22 at 11:31 AM the 500 hall medication cart was observed unlocked and unattended at the 500 hall nurses ' station. There was no nurse observed to be on the hall or in eyesight of the cart. During the observation, non-nursing staff were at the nurses ' station and around the medication cart. At 11:34 AM the maintenance director was observed to walk up to the nurses ' station. At 11:35 AM the maintenance director noted the medication cart was unlocked and proceeded to lock the medication cart. During an interview on 3/9/22 at 11:35 AM the Maintenance Director stated because he saw the 500 hall medication cart was unlocked and the nurse was not in eyesight of the cart, he locked the cart for the nurse.	F 761	by the facility Director of Nursing regarding the requirement to ensure medication carts are not left unlocked or with medications on top of the cart when unattended. This education was completed on 3/8. The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. On 3/8 the Director of Nursing completed a 100% audit of all other medication carts to ensure they were secured appropriately. No other cart was found to be out of compliance. Systemic changes implemented to ensure the alleged deficient practice does not reoccur: 100% of the licensed nursing staff will receive in-service education from the facility Director of Nursing or designee regarding requirement to ensure medication carts are not left unlocked or with medications on top of the cart when unattended. This education is to be completed by 3/25, with any licensed staff receiving the education prior to being allowed to begin working. Monitoring to ensure that the alleged deficient practice does not re-occur starting on 3/28, the facility Director of Nursing, or designee will audit all facility medication carts to ensure medication carts are not left unlocked or with medications on top of the cart when unattended. This monitoring will be recorded on the Medication storage Quality Improvement tool and to be completed daily, Monday through Friday x5 day; weekly x4 weeks; then monthly x 2 months. The results from these audits	

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F 761	Continued From page 10 During an interview on 3/9/22 at 11:41 AM Nurse #4 stated medication carts should be locked when unattended. She stated it was oversight that it was unlocked this time and should have been locked before it was left unattended. During an interview on 3/9/22 at 1:31 PM the Director of Nursing stated medication carts should be locked when unattended.	F 761	will be presented to the facility's Quality Assurance and Performance Improvement Committee meetings for 3 months or until a pattern of substantial compliance is achieved.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		3/25/22

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F 880	Continued From page 11 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 Based on observation, record review, and staff and Wound Physician interviews the facility failed to perform hand hygiene during wound care for 1 of 2 residents reviewed for wound care. (Resident #1) Findings included: During observation of wound care on 3/7/22 at 1:29 PM the Wound Care Nurse was observed performing wound care to Resident #1 ' s pressure ulcers. The Wound Care Nurse was observed to first perform hand hygiene and then apply two pairs of gloves to her hands, one pair of gloves over the other one. She then removed the old dressing from the left ankle stage II pressure ulcer and discarded the old dressing. The Wound Care Nurse then cleansed the left ankle stage II pressure ulcer. She then discarded the cleanser and first pair of gloves leaving the second pair on her hands. She then applied silver alginate and a dry dressing to the stage II pressure ulcer on Resident #1 ' s left ankle. The Wound Care Nurse then swabbed Resident #1 ' s left unstageable pressure ulcer on his heel with betadine and discarded the swab and second pair of gloves and performed hand hygiene. She then donned another pair of gloves and swabbed Resident #1 ' s right unstageable pressure ulcer on his heel with betadine and discarded the swab and gloves and performed hand hygiene. During an interview on 3/7/22 at 1:33 PM the Wound Care Nurse stated she double gloves when providing wound care to wounds in the same location. She stated she went from dirty to clean on the wound and then took the first pair off to put the dressing on and move to the second wound on Resident #1 ' s left heel. Once this was	F 880	Identify the root cause resulting in the facilities failure: A thorough analysis of contributing factors which lead to identifying the root cause regarding the failure to perform hand hygiene and apply a new glove, instead of “double gloving” between removing a dirty dressing for resident 1 and cleaning or applying a new dressing during wound care. The internal investigation included: • The Director of Nursing and Administrator conducted interviews on 3/21 with the wound care nurse and the wound care doctor identified in the 2567 • The completion of the 5 WHYS WORKSHEET in collaboration with the QAPI Committee and the Choice Health Management Nurse Consultant The analysis concluded that the root cause is a lack of education of relevant practices for infection control regarding wound care being provided to the facility wound care staff and the facility Director of Nursing. Immediate correction was achieved for the alleged deficient practice: the status of resident # 1’s wounds were assessed by the facility Director of Nursing on 3/7 and it was determined that the technique used did not cause detriment or cause infection to the resident. The facility Director of Nursing and wound care nurse received 1:1 education regarding the procedure necessary to maintain effective infection control while performing wound care. This education was provided by the Choice health Management Nurse Consultant on 3/23/2022. The facility recognizes that all residents	

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F 880	Continued From page 13 done, she would need to discard and change gloves because she was moving to a new location. When the dressing change was described to the Director of Nursing on 3/7/22 at 4:00 PM the Director of Nursing stated that she believed the use of double gloves and order in which the care was given was correct and there were no infection control concerns. She further stated she was the infection control nurse at the time. During an interview on 3/7/22 at 4:28 PM the Wound Care Doctor stated she was just educated on wound care at a wound conference, and she needed to be reeducated because her technique was very similar to the Wound Care Nurse, and she was enlightened. She stated the wound care nurse should not have double gloved, should have performed hand hygiene, and donned a new pair of gloves after removing the old dressing prior to cleansing the wound. The Wound Care Nurse also should have performed hand hygiene and donned a new pair of gloves before providing care to the next wound. She stated this was per Centers for Medicare and Medicaid Services (CMS) guidelines of infection control during wound care.	F 880	have the potential to be affected by the alleged deficient practice. The facility Wound Care Doctor and/or the facility Director of Nursing reviewed all residents requiring wound care on 3/18 to determine if any residents have developed an infection in their wounds. No infected wounds were identified during the review. Systemic changes implemented to ensure the alleged deficient practice does not reoccur: 100% of the facility's wound care team is to receive in-service education from the facility Director of Nursing or designee on the procedure necessary to maintain effective infection control as it pertains to hand hygiene while performing wound care. This education is to be complete by 3/25. Monitoring to ensure that the alleged deficient practice does not reoccur starting on 3/28, the facility Director of Nursing, or designee will audit 10% of all wound care procedures to ensure they are done utilizing proper infection control technique. This monitoring will be recorded on the Wound Care Quality Improvement tool and to be completed daily, Monday through Friday x5 day; weekly x4 weeks; then monthly x 2 months. The results from these audits will be presented to the facility's Quality Assurance and Performance Improvement Committee meetings for 3 months or until a pattern of substantial compliance is achieved.	