Electronically delivered
May 9, 2022

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

RE: CCN: 245316
Cycle Start Date: April 25, 2022

Dear Administrator:

On April 25, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On February 3, 2022, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the

following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, New Richland Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effectiveApril 25, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F"and/or an E tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after

receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's

informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 9, 2022

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

Re: Event ID: FN2N11

Dear Administrator:

The above facility survey was completed on April 25, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	C 04/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW RICHLAND CARE CENTER	**312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072**

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F 000	INITIAL COMMENTS On 4/21/22, 4/22/22, and 4/25/22, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. An IJ at F600 began on 1/25/22, at 6:30 p.m., when culinary aide (CA)-A observed R1 touching NA-A breast while NA-A stood above R1 in his wheelchair in resident room. CA-A reported this to her supervisor, culinary director (CD)-A but was told to wait to report to the facility social worker (SW)-A in the morning. NA-A continue to work her shift. That same day, NA-G observed another incident of alleged sexual abuse at 10:45 p.m. involving NA-A and R1. The IJ was removed, and the deficient practice was corrected on 2/3/22, prior to the start of the survey and therefore is being issued at Past Noncompliance. The following complaint was found to be SUBSTANTIATED: H5316042C (MN80495) with a deficiency issued at F600 IJ at Past Noncompliance. The following complaint was found to be UNSUBSTANTIATED: H5316041C (MN82550). Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		

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

Electronically Signed

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.

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F 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect 1 of 1 residents (R1) from sexual abuse when an incident of sexual abuse was observed, was not reported to the administrator, and led to a subsequent second observation of sexual abuse involving nursing assistant (NA)-A. This resulted in an Immediate Jeopardy (IJ) for R1. The IJ began on 1/25/22, at 6:30 p.m., when culinary aide (CA)-A observed R1 touching NA-A breast while NA-A stood above R1 in his wheelchair in resident room. CA-A reported this to her supervisor, culinary director (CD)-A but was told to wait to report to the facility social worker (SW)-A in the morning. NA-A continue to work her shift. That same day, NA-G observed another incident of alleged sexual abuse at 10:45 p.m. involving NA-A and R1. The IJ was removed, and the deficient practice was corrected on 2/3/22, prior to the start of the survey and therefore is	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2 being issued at Past Noncompliance. Findings include: R1's Face Sheet with admission date of 8/16/19, included diagnoses of Parkinson's Disease (progressive nervous system disorder that affects movement), Lewy Body Dementia (chemical brain changes that leads to decreased cognition, movement, behavior, and mood), visual hallucinations, and anxiety disorder. R1's quarterly Minimum Data Set (MDS) assessment documented 2/1/22, indicated R1 was cognitively intact based on the Brief Interview for Mental Status assessment; R1 had verbal behavioral symptoms directed towards others; and R1 required extensive assistance with bed mobility, transfer, locomotion, dressing, toileting, and personal hygiene. R1's Care Plan last reviewed 3/16/22, documented R1 is prescribed Zoloft, an antidepressant medication, to treat his depression, Zyprexa to treat behavioral disturbances of visual hallucinations such as seeing rats and animals with tails in his room, delusional thinking and paranoid thoughts due to Lewy Body Dementia and requires a private room due to roommates requesting to not be with R1, due to verbal behaviors. During an interview on 4/21/22, at 11:25 a.m. R1 stated NA-A had kissed and hugged him. R1 indicated they had a close relationship with each other, and he did not want NA-A to get into trouble. R1 also inquired if he was in trouble due to their relationship.	F 600		

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F 600	Continued From page 3 During an interview on 4/25/22, at 7:32 a.m. CA-A stated she was passing snacks to residents at approximately 6:30 p.m. on 1/25/22, and when she entered R1's room she observed NA-A standing next to R1, while R1 was sitting in his wheelchair, and R1 was touching NA-A breasts (over her clothing). When NA-A saw CA-A, she immediately stood back and told R1 she would return later to help him. CA-A stated she left the facility at the conclusion her shift on 1/25/22, at approximately 7:30 p.m. and at 8:16 p.m. she texted CD-A and stated, "Hi CD-A, I walked into a resident's room and saw something I think I should report. I looked at the reporting requirements in the handbook and didn't see who to contact. Who should I contact to do so?" On 1/25/22, at 8:37 p.m. CD-A replied, "call social worker (SW) tomorrow she is the social worker, and she handles these types of situations, thanks." On 1/26/22, at approximately 7:30 a.m. CA-A called SW and reported her observation. During an interview on 4/22/22, at 11:31 a.m. CD-A stated CA-A did text him about her observation on 1/25/22, and that he instructed her to contact SW the next morning, on 1/26/22. CD-A stated he thought CA-A was reporting something about a problem with kitchen operations and not a resident concern. CD-A stated he did not inquire of any additional details of CA-A's text. CD-A stated since he has had the reeducation, he understands he needed to get more information to determine if the concern was abuse. During an interview on 4/22/22, 8:50 a.m. NA-G stated at the end of shift report on 1/25/22, she started rounding to see residents at approximately 10:45 p.m. and when she looked in	F 600		

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F 600	Continued From page 4	F 600		

R1's room she observed R1 and NA-A kissing on the lips. NA-A stated she immediately went to registered nurse (RN)-A and reported the incident.

During an interview on 4/22/22, at 11:05 a.m. RN-A stated NA-G reported at 10:45 p.m. that she just observed NA-A and R1 kissing on the lips. RN-A immediately left report and went to look for NA-A. RN-A determined NA-A had left the building since her shift had ended. RN-A stated she did not immediately report the allegation because NA-A was out of the building and all residents were safe. RN-A stated she reported the allegation to SW at approximately 7:15 a.m. on 1/26/22.

During an interview on 4/25/22, 9:49 a.m. NA-C stated NA-A would spend 45-60 minutes doing R1's cares and would do cares independently that should have required two nursing assistants. NA-A was consistently missing during her shift and could always be found with R1. This would happen even if NA-A was assigned to 100 Hallway and R1 lived in the 200 Hallway.

During an interview on 4/25/22, at 12:03 p.m. licensed practical nurse (LPN)-A stated she had concerns with the inappropriate amount of time NA-A spent with R1 and that she would disappear during her shift. The amount of time NA-A spent with R1 impacted the rest of the residents receiving timely care. LPN-A stated her concerns were not reported to the leadership team.

During an interview on 4/25/22, at 12:05 p.m. NA-D stated NA-A spent a lot of time with R1, and that she had a direct conversation with NA-A about how bad it looked that she was in R1's

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F 600	Continued From page 5	F 600		

room so much. At times NA-A would spend up to an hour with R1 and not help her colleagues with call lights. There was a noticeable difference starting at the end of 2021 that NA-A seemed to spend even more time with R1. Even if NA-A was assigned to the 100 Hallway, she would go to the 200 Hallway to give R1 his weekly shower. NA-D stated her concerns were not reported to the leadership team.

During an interview on 4/25/22, at 12:09 p.m. NA-E started having concerns with NA-A starting around December 2021. NA-A would constantly disappear and could not be found. Eventually it was discovered NA-A would be with R1. The amount of time NA-A spent with R1 created timely resident care concerns and impacted what other staff had to do to cover for NA-A. NA-E stated there was an email sent from 200 Hallway to administration about staff concerns with NA-A but never heard if there was a reply to the email.

During an interview on 4/25/22, at 12:19 p.m. NA-F stated there was discussion with other nursing assistants on how much time NA-A was spending with R1 and the impact on other resident care. Even if NA-A was assigned to the 100 Hallway, she would end up disappearing and staff knew she was with R1. If NA-A was assigned to the 100 Hallway she would request to move over to the 200 Hallway where R1's room was. There was a noticeable change in January 2022 on how much time she spent with R1, and that NA-A did not seem to be herself. NA-F stated the concerns were not reported to the leadership team.

During an interview on 4/25/22, at 12:50 p.m. LPN-B stated NA-A would spend up to an hour

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F 600	Continued From page 6	F 600		

completing cares for R1. It really left the rest of the staff short and had an impact on the rest of the resident care due to being short one nursing assistant. LPN-B stated the concerns were not reported to the leadership team.

An email from LPN-B titled, 200 Nurse Hallway, dated 1/11/22, at 9:21 p.m. was sent to administrator, director of nursing (DON), and nurse manager (NM)-A. The email detailed staff concerns related to NA-A who was continuously missing during her shift and that it had become a problem. LPN-B stated nursing assistants are increasingly frustrated, and staff are not relying on NA-A for help.

A reply email sent by ADM on 1/11/22, at 9:24 p.m. replied, "if NA-A does not listen to your direction send her home and I will take care of it when I'm back Thursday. This is unacceptable behavior and won't be tolerated." During an interview on 4/25/22, at 11:25 a.m. Administrator and DON stated there is no documentation of following up with NA-A and the 200 Hallway concerns. Administrator stated, NA-A is a casual straight evening nursing assistant and did not work for several days after the email was received and administrator did not follow up on the concern. Further, administrator stated there is no documentation that anyone from leadership followed up with the concern. Administrator and DON stated this was the first-time staff had informed them of concerns with NA-A's interaction with R1. Further, if there was abuse, suspicion of abuse, or inappropriate care, their expectation was that it would be reported immediately to the leadership team.

During document review, the facility Investigation

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F 600	Continued From page 7 Form created by NA-D on 11/19/21, at 9:45 p.m. described her observation of NA-A kneeling on R1's bed and hugged him for greater than five minutes. Documentation of the investigation dated 1/26/22, by SW documented an interview with R1, who denied anyone had hugged or kissed him, but did not contain any documentation of interviewing NA-A. During an interview on 4/22/22, 10:40 a.m. SW stated her investigation of the Investigation Form created by NA-D on 11/19/21, at 9:45 p.m. concluded the allegation was not credible and she classified as unsubstantiated. SW indicated there was no proof the event occurred. SW-A also stated she did not interview NA-A and there is no documentation of anyone following up with NA-A on the concern. During an interview on 04/25/21, 2:10 p.m. unit manager (UM)-A stated there was an email that was sent to administration about how much time NA-A was spending with R1. The email indicated nursing assistants were increasing frustrated of how NA-A would disappear from the floor and not being able to rely on her for resident care. The email indicated how the charge nurse tried to redirect NA-A and keep her on track, but those efforts proved to be unsuccessful. UM-A stated there is no documentation of the leadership response but does remember assigning a registered nurse to stay late after her shift to observe NA-A during her evening shift. There did not seem to be any concern with the observation, so nothing was brought forward. UM-A stated no one talked with NA-A about the concerns. UM-A was unable to provide documentation of observation shift date, time, assigned RN or observation details.	F 600		

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F 600	Continued From page 8	F 600		

During an interview on 4/25/22, at 3:24 p.m. NA-A flatly denied touching, hugging, or being unprofessional with R1. NA-A specifically stated she did not kiss R1, nor did she allow him to touch her breasts. She did, however, acknowledge she spent extra time with R1. NA-A was unaware that staff had issues with her spending long periods of time with R1 and that no one had ever expressed a concern to her.

During an interview on 4/25/22, at 12:55 p.m. power of attorney (POA) stated R1 was depressed that NA-A was terminated from the facility. POA further stated R1 asked him if he was in trouble because of the relationship he had with NA-A.

The facility, Vulnerable Adult Reporting Guide, revised date 3/12/18, directed that health care workers are mandatory reporters and are required to report any witnessed or hearing of a complaint of resident abuse to immediately notify the administrator, DON or social worker. The policy further directs staff to not leave a text, voice mail, or their supervisor a note. The policy mandates the reporter must talk directly to ADM first, then contact the DON or social worker if ADM is not available.

The Past Noncompliance immediate jeopardy began on 1/25/22. The immediate jeopardy was removed, and the deficient practice was corrected on 2/3/22, after the facility removed NA-A from the scheduled pending investigation and subsequently terminated her employment, reported sexual abuse allegations, investigated allegations of sexual abuse and implemented re-education for all staff in the facility. All staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245316	A. BUILDING _____ B. WING _____	C 04/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW RICHLAND CARE CENTER	**312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072**

(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 600	Continued From page 9 were mandated to attend an educational presentation of Elder Sexual Abuse in Care Facilities: Detection, Response, and Prevention Part I & II. Education documentation for facility staff was reviewed by surveyor and interviews were conducted to ensure competency related to detection, response and reporting while onsite.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00748	A. BUILDING: _____ B. WING _____	C 04/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW RICHLAND CARE CENTER	312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/21/22, 4/22/22, and 4/25/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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	00748	A. BUILDING: _____ B. WING _____	C 04/25/2022

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2 000	Continued From page 1 SUBSTANTIATED: H5316042C (MN80495) however no licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5316041C (MN82550). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		