Electronically delivered

October 7, 2021

Administrator
Hilltop Care Center
410 Luella Street
Watkins, MN 55389

RE: CCN: 245358
Cycle Start Date: September 2, 2021

Dear Administrator:

On September 27, 2021, we informed you that we may impose enforcement remedies.

On September 20, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 2, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 2, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 2, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. 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)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 2, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Hilltop Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 2, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" 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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 2, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING _____ B. WING _____	C 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	**410 LUELLA STREET WATKINS, MN 55389**

(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 On 9/20/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED with a deficiency cited at F755: H5358014C (MN76378) H5358015C (MN76872) H5358016C (MN76739) H5358017C (MN76636) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		10/26/21

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

Electronically Signed | 10/13/2021

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 755	Continued From page 1 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify corrective action following a drug diversion to develop a systematized oversight process to better identify discrepancies and unusual patterns related to narcotic and controlled medication administration, reconciliation and documentation practices for 4 of 4 residents (R1, R2 ,R3 and R4) who received controlled substance. Findings include: R1's admission Minimum Data Set (MDS), dated 7/27/21, indicated R1 had intact cognition, hip	F 755	The facility has requested IDR process for this deficiency. 1) The nurse responsible for diverting narcotics from R1, R2, R3, & R4 was suspended pending investigation when diversion was noted and terminated from employment following investigation. 2) All residents receiving controlled substances had their records audited for any diversion and no diversion was noted. Nurse responsible for diversion was terminated following investigation. 3) The Controlled Substance Policy was revised on October 13, 2021, and	

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F 755	Continued From page 2 fracture and received opiod medication with pain rated at a 10 (severe). R1's physician order dated 7/21/21, indicated an order for Oxycodone 5 mg give orally as needed every 4 hours for pain rated 3-6 and give 10 mg for pain rated 7-10 using a scale of 1-10. An initial facility report was submitted to the State Agency (SA) on 9/11/21, indicated R1's narcotic ledger and electronic medical record (EMAR) had multiple discrepancies and timecard report had discrepancies with documentation. The report indicated the facility policy or procedure was followed at the time of the incident. Following the initial investigation into suspected medication diversion ; the nurse licensed practical nurse (LPN)-A did admit to steeling approximately 5-10 milligram (mg) tablets of PRN (as needed) Oxycodone (controlled substance to treat moderate to severe pain) from R1 and discovered diversion began upon nurse date of hire in July 2021. The facility investigation report identified the discovery of an excessive amount of PRN medications administered that did not coincide with the EMAR over a four month period and multiple dates and times had been falsified. Further the report indicated that LPN-A was not in the building on multiple days the medication was documented as administered and medications were given in excess of the physician order. The report indicated LPN-A was terminated, a complaint was filed to the Board of Nursing and staff education paper content and video and in-services hosted by pharmacy consultant regarding medication diversion was scheduled for a future date. During interview on 9/20/21, at 9:30 a.m. the	F 755	licensed nurses were educated on policy update. The Consultant Pharmacist was consulted regarding diversion and review of facility policy. Nursing staff completed drug diversion education with consultant pharmacist on October 8th, 2021. The nurse responsible for the drug diversion was solely responsible for the problem and during the investigation it was noted that the nurse had a substantiated drug diversion at another facility on February 9, 2021 filed with MDH case number (h5364034m). The nurse was hired at Hilltop Health Care Center on June 16, 2021 and nothing flagged on the background study or license verification for this nurse to indicate that prior drug diversion had occurred. The nurse was allowed to work on the MDH crisis staffing team and traveled to multiple facilities during Covid. This is not a facility system problem but a state system problem that allows criminals to be hired by facilities unbenounced to them. This systems error is an issue with the reporting agencies of the State of MN. 4) The DON or designee will audit controlled substance records weekly x 1 month, then bi-monthly x 1 month and reviewed at the QAPI meeting. Ongoing audits will be determined by the Quality Performance and Improvement Committee.	

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F 755	Continued From page 3	F 755		

director of nursing (DON) stated the charge nurse called on 9/11/21, to inform her there was a discrepancy with R1's Oxycodone. It appeared R1 had been taking the medication when his plan was to taper off. When the nurse asked R1 about this, he informed the nurse that he had not taken the medication for a week, which was not consistent with the record. That was when the charge nurse knew something was wrong. We as a team met with LPN-A and she admitted to taking 5-10 tablets of R1's Oxycodone and we terminated her and began our internal investigation and found out she had been diverting medications with three additional residents and all of them were receiving Oxycodone as needed for pain. The DON stated the Board of Nursing was notified and a police report was filed with Meeker County.

The following reports were filed to the SA in regards to there investigation:

R2 admission MDS dated 7/5/21, indicated R1 was cognitively intact, had medically complex condition and frequent very severe pain and receive PRN opiod's.

R2's physician orders dated 7/28/21, indicated she received Oxycodone 5 mg tablets every 6 hours as needed for moderate to severe pain.

A facility reported incident dated 9/16/21, indicated R2 had multiple ledger discrepancies and time card discrepancies. The report investigation indicated it was found LPN-A on multiple occasions was documenting administration of medication in the Narcotic ledger and not entering in the EMAR. There was a total of 21 tablets that had not been

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F 755	Continued From page 4	F 755		

documented in the EMAR and there was a few pages in the ledger with the dates and times duplicated for the scheduled PRN doses. It was found difficult to determine if the diversion caused harm to the resident and all the doses taken were PRN.

R3's admission MDS dated 8/2/21, indicated R3 was cognitively intact had non-traumatic spinal cord dysfunction, had pain rated at 5 with occasional pain and received as needed opiod's.

R3's physician orders dated 7/26/21, indicated R3 received Oxycodone 5 mg every 3 hours for for severe pain rated from 7-10.

A facility reported incident dated 9/16/21, indicated R3 had narcotic ledger/ EMAR and time card with multiple discrepancies. The report further indicated from looking at the ledger it appeared LPN-A administered the medication on average twice on her shift and received multiple doses on her shift. In addition the report indicated it was difficult to determine if it caused harm to R3.

R4's quarterly MDS dated 9/8/21, indicated R4 had non-traumatic brain dysfunction, severely cognitively impaired, vocalized pain and had facial expressions of pain. In addition the MDS indicated she received opiod's for pain.

R4's physician orders dated 3/21/21, indicated R4 received Oxycodone 5 mg as needed twice daily for moderate to severe pain.

R4's facility reported incident dated 9/16/21, indicated had narcotic ledger/ EMAR and time card with multiple discrepancies. The report

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F 755	Continued From page 5	F 755		

further indicated for R4 the documentation of excessive PRN administration in the narcotic paper ledger when LPN-A was working as well as falsification of dates and times, multiple paper documentation entries do not coincide with the EMAR. In addition to R4's cognitive impairment it was difficult to determine the effect on the resident. It was identified 24 tablets of Oxycodone that were documented as administered in the narcotic ledger but not entered into the EMAR system.

During interview on 9/20/21, at 10:00 a.m. the DON stated after they terminated LPN-A when she admitted to taking 5-10 tablets from R1 they completed a internal investigation on all residents receiving controlled substances/narcotics, reviewing the narcotic ledgers, EMARs, time cards and they found LPN-A diverted 122 tablets of Oxycodone from R1,R2,R3 and R4. The DON stated the staff followed there policies and procedures but after the findings she was planning to complete a 11 minute training with the nursing staff which included a video and paperwork for the nurses. The DON stated she had been working on the training but has not yet started the training for the staff. The DON did state she does have a training set up with the pharmacy to help identify diversion in October. Although it had been 9 days since the first incident identified diversion and the DON was aware of the discrepancy of narcotic ledger, EMAR and time card the staff had not yet been trained to identifiy diversion.

During interview on 9/21/21, at 10:41 a.m. registered nurse (RN)-A stated she was the nurse who identified the discrepancy of the diversion with LPN-A. RN-A stated she was giving

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F 755	Continued From page 6	F 755		

Oxycodone more than it was scheduled on a shift and that is what made her look at the times and when RN-A noticed this on 9/11/21 she contacted the DON and a meeting was made. RN-A stated LPN-A would make it so the narcotic record did not match the EMAR and she would empty the card and put them in random times in the narcotic ledger and in fact even spilled water on the narcotic ledger so we could not read it.

During interview on 9/20/21, at 11:00 a.m. lead detective from Meeker County indicated he was assigned to the case with LPN-A and stated when interviewed LPN-A admitted to taking 5-10 tablets of Oxycodone from the facility.

Although the facility had policy and procedures in place to prevent narcotic diversion, once they did identify a diversion they failed to assess how the diversion occurred and put measures in place to prevent additional diversion practices.

Facility policy Controlled Substances dated 1/30/20, indicated "The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parities, and shall give the Administrator a report of such findings."

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 7, 2021

Administrator
Hilltop Care Center
410 Luella Street
Watkins, MN 55389

Re: Event ID: BT9S11

Dear Administrator:

The above facility survey was completed on September 20, 2021 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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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 9/20/21 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were found to be	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00798	A. BUILDING: _____ B. WING _____	C 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	**410 LUELLA STREET WATKINS, MN 55389**

(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) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED with no licensing orders issued: H5358014C (MN76378) H5358015C (MN76872) H5358016C (MN76739) H5358017C (MN76636) The 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		