



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 25, 2024

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: CCN: 245618
Cycle Start Date: February 1, 2024

Dear Administrator:

On April 9, 2024 and April 24, 2024, the Minnesota Department(s) of Health and Public Safety, completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2024

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: CCN: 245618
Cycle Start Date: February 1, 2024

Dear Administrator:

On February 1, 2024, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 1, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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.

Walker Methodist Westwood Ridge II

February 9, 2024

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a small dot above the 'i' in Downing.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 9, 2024

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: Event ID: 42YB11

Dear Administrator:

The above facility survey was completed on February 1, 2024 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245618	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2024
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NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II	STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118
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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
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F 000	<p>INITIAL COMMENTS</p> <p>On 1/31/24 through 2/1/24, a standard abbreviated survey was conducted at your facility. Your facility was in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed: H56189328C (MN00100373) H56189385C (MN00100107) H56187415C (MN00098736) H56189356C (MN00098638) H56189356C (MN00098243)</p> <p>An incidental finding was issued at F609. 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.</p> <p>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.</p>	F 000		
F 609 SS=D	<p>Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown</p>	F 609		3/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/19/2024

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 609	<p>Continued From page 1</p> <p>source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure allegations of misappropriation of property were reported within 24 hours to the State Agency (SA) for 1 of 5 residents (R1) reviewed for allegations of misappropriation of property.</p> <p>R1's discharge Minimum Data Set (MDS) dated 1/29/24 indicated R1 was cognitively intact and had almost constant pain that occasionally affected her sleep with an average pain rating of 6/10 (Pain scale where 0 is no pain and 10 is the worst pain imaginable)</p> <p>R1's Provider Orders included oxycodone (narcotic pain medication) 10 milligram (mg)</p>	F 609	<p>Corrective action(s) accomplished for those patients found to have been affected by the deficient Practice: On 1/29/24, patient, family, social worker, and Director of Nursing met to discuss concerns noted from 1/27/24. Facility followed up with the team member involved in the incident. R1 discharged from facility on 1/29/24.</p> <p>Corrective action taken to identify other patients having the potential to be affected by the same deficient practice: Facility conducted resident interviews on 1/29/24. Staff member directly involved in the incident was removed from the schedule.</p>	

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F 609	<p>Continued From page 2</p> <p>tablet by mouth every 4 hours as needed (PRN) for pain level 8-10/10 and Ambien (sedative) 5 mg by mouth every 24 hours as needed for sleep.</p> <p>R1's Medication Administration Record (MAR) for January 2024 indicated R1 had requested oxycodone on 1/27/24 for a pain rating of 8/10, and Ambien to help her sleep.</p> <p>A Facility Reported Incident (FRI) submitted on 1/29/24 at 12:45 p.m. (approximately two days after the incident was reported by R1) to the SA indicated R1 alleged licensed practical nurse (LPN)-B had stolen medication.</p> <p>On 1/31/24 at 12:45 p.m., R1 stated earlier in the week, she had experienced increased pain and was unable to fall asleep after LPN-B gave her oxycodone and Ambien she had requested. R1 stated she always fell asleep quickly after taking those two medications. R1 stated night she could not fall asleep. R1 stated she had not looked closely at her pills because she trusted the nurse had given her the correct medications. R1 stated LPN-B did not work with R1 again until Saturday. Saturday evening, R1 stated she requested as needed oxycodone and Ambien at 8:45 p.m. LPN-B brought the pills into the room, set them on the over the bed table then left the room. R1 examined the pills and knew the white oxycodone tablet looked different than the ones she had taken earlier in the day. R1 requested LPN-A to confirm the white pill was oxycodone. R1 stated LPN-A told her the white pill looked like melatonin (used to promote sleep), not oxycodone. R1 stated she filed a police report that night about a nurse stealing her narcotic medication.</p> <p>On 1/31/24 at 2:32 p.m., LPN-A stated she was</p>	F 609	<p>Narcotic record on medication cart reviewed for inconsistencies or concerns.</p> <p>Systematic change(s) to ensure deficient practice does not recur: Director of Nursing, Licensed nurses and certified nursing assistants will be re-educated on Vulnerable Adult Abuse Prevention Plan and Suspicion of a Crime Reporting policy, including the importance of timely reporting.</p> <p>Required monitoring to ensure deficient practice will not recur: 5 residents will be interviewed weekly for 4 weeks to ensure no misappropriation of property has occurred. These interviews will be reviewed at time of the interview by the DON/designee and follow up will occur as necessary. These interviews will be brought to the facility QAPI meeting on March 28 for review and further recommendation.</p> <p>5 team members will be interviewed weekly for 4 weeks to ensure appropriate awareness of Vulnerable Adult Abuse Prevention Plan and Suspicion of a Crime Reporting policy and requirements for timely reporting. These interviews will be brought to the facility QAPI meeting on March 28 for review and further recommendation.</p>	

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F 609	<p>Continued From page 3</p> <p>the charge nurse on 1/27/24. LPN-A stated R1 told her LPN-B had stolen her narcotic medication. R1 told her she had called the police to file a report. LPN-A notified the director of nursing (DON) who instructed LPN-B to stop passing medications and to not go into R1's room. LPN-A stated the DON was the person who would file a report with the SA.</p> <p>On 2/1/24 at 3:54 p.m., the DON stated she was notified of a medication error on the evening of 1/27/24. The DON stated a report was not filed that evening because she was not informed of the theft allegation. The DON stated she did not know the reason for the police report. The DON stated during a care conference on 1/29/24, R1 again accused LPN-B of stealing medication on 1/27/24. The DON stated R1 said she experienced increased anxiety when LPN-B had worked on Sunday, even though LPN-B did not work directly with R1.</p> <p>The facility's Vulnerable Adult Policy dated 3/15/23 directed the facility promotes the right of each resident to be free from verbal, mental, sexual, or physical abuse, neglect, exploitation, mistreatment, or misappropriation of resident property. Misappropriation of resident property was defined to include diversion of the resident's medications. Alleged violations are to be reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p>	F 609		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27996	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2024
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NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II	STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 1/31/24 through 2/1/24, 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 reviewed H56189328C (MN00100373)</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

02/19/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27996	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2024
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2 000	<p>Continued From page 1</p> <p>H56189385C (MN00100107) H56187415C (MN00098736) H56189356C (MN00098638) H56189356C (MN00098243) NO licensing orders were issued. 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.</p>	2 000		