

**Texas Health and Human Services Commission  
Office of Inspector General - Utilization Review Unit  
Nursing Facility Utilization Review**





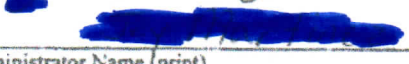

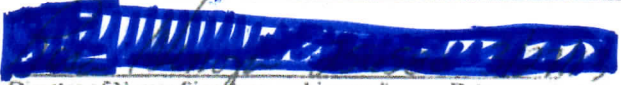

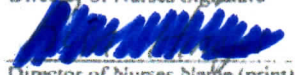


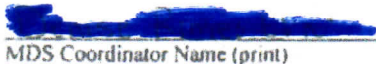
**PRELIMINARY STATEMENT OF FINDINGS**

Vendor No.: 4859  
 Region: 10  
 Nursing Facility: Nazareth Hall Nursing Center  
 Address:  
 4614 Trowbridge Drive TX 79903

Number of Forms Reviewed: 55  
 Number of RUG Changes: 53  
 Number of Hospice Forms Reviewed: 3  
 Onsite Review Completion Date: 3-27-2013

**ATTESTATION:** As the nursing facility and hospice representative(s) in attendance, I understand that this document serves as notification of the on-site review results and areas identified and discussed. The attached "List of Reviewed Assessments" includes the MDS forms reviewed during this Utilization review and the item and RUG change(s) made by the Nurse Reviewer(s). I understand that all RUG changes as a result of this review will be processed and will be retroactive for the effective time period of the original MDS form. I acknowledge receipt of the requirements for submitting a reconsideration review request.

I was given the opportunity to ask questions during the onsite review and review conference. Any alleged violation of Texas Administrative Code (TAC), Title 1, Part 15, Chapter 357, Subchapter M (relating to Fraud or Abuse Involving Medical Providers) and Code of Federal Regulations, Title 42, Chapter IV, Part 455 Program Integrity: Medicaid, which would include claims submission with a pattern of inappropriate coding or billing that results in unnecessary costs to the Medicaid program, may result in a referral for investigation for fraud to the Office of Inspector General, Medicaid Provider Integrity.

Nursing Facility's Designated Representative(s):			Other Provider Representative(s)		
 Administrator Signature	 Date		 Signature	 License #      Date	
 Administrator Name (print)			 Name (print)		
 Director of Nurses Signature	 License #      Date			License #      Date	
 Director of Nurses Name (print)			Name (print)		
 MDS Coordinator Signature	 License #      Date			License #      Date	
 MDS Coordinator Name (print)			Name (print)		

Initials: NF & Hospice Representative(s)

Date:

OIG-UR Nurse Reviewer(s)

Date:

3/27/2013