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 attendence, 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)
[redacted] Administrator Signature [redacted] Date [redacted] Administrator Name (print)	[redacted] Signature License # Date [redacted] Name (print)
[redacted] Director of Nurses Signature License # Date [redacted] Director of Nurses Name (print)	License # Date Name (print)
[redacted] MDS Coordinator Signature License # Date [redacted] MDS Coordinator Name (print)	License # Date Name (print)

Initials: NF & Hospice Representative(s) [redacted] Date: [redacted] OIG-UR Nurse Reviewer(s) [redacted] Date: [redacted]