

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

PRINTED: 07/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2019												
NAME OF PROVIDER OR SUPPLIER KMG HOMECARE UNLIMITED, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 307 E 38TH STREET ANDERSON, IN 46013														
(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												
G 000	<p>INITIAL COMMENTS</p> <p>This visit was for a Federal recertification and State Licensure survey of a home health agency.</p> <p>Facility #: 013514</p> <p>Dates of survey: 6-20-19, 6-21, 6-25, and 6-26-19</p> <p>Provider #: 15K127</p> <p>Medicaid #: 201267560</p> <p>Census: Unduplicated skilled admissions prior 12 months: 5</p> <p>Current active census: 68</p> <table> <tr> <td>Clinical Records Reviewed:</td> <td>Home visit with clinical record review</td> <td>3</td> </tr> <tr> <td>visit, active</td> <td>Clinical record review, no home</td> <td>2</td> </tr> <tr> <td>visit, closed</td> <td>Clinical record review, no home</td> <td>2</td> </tr> <tr> <td></td> <td>Total</td> <td>7</td> </tr> </table> <p>KMG Homecare Unlimited, LLC, was found to be in compliance with the requirements of 42 CFR 484 and 410 IAC 17 in regard to the Recertification and State Licensure Survey.</p> <p>Quality Review completed 07/01/19</p>	Clinical Records Reviewed:	Home visit with clinical record review	3	visit, active	Clinical record review, no home	2	visit, closed	Clinical record review, no home	2		Total	7	G 000		
Clinical Records Reviewed:	Home visit with clinical record review	3														
visit, active	Clinical record review, no home	2														
visit, closed	Clinical record review, no home	2														
	Total	7														

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

TITLE

(X6) DATE

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.