STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K127	A. BUILDING _____ B. WING _____	06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KMG HOMECARE UNLIMITED, LLC	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	INITIAL COMMENTS	G 000		

This visit was for a Federal recertification and State Licensure survey of a home health agency.

Facility #: 013514

Dates of survey: 6-20-19, 6-21, 6-25, and 6-26-19

Provider #: 15K127

Medicaid #: 201267560

Census: Unduplicated skilled admissions prior 12 months: 5
Current active census: 68

Clinical Records Reviewed: Home visit with clinical record review 3
Clinical record review, no home visit, active 2
Clinical record review, no home visit, closed 2
Total 7

KMG Homecare Unlimited, LLC, was found to be in compliance with the requirements of 42 CFR 484 and 410 IAC 17 in reard to the Recertification and State Licensure Survey.

Quality Review completed 07/01/19

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