

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/23/2012
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT MARYVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2848 SEVIERVILLE RD MARYVILLE, TN 37604		
(X4) ID PREFIX TAG N 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  During a complaint investigation at Asbury Place at Maryville on July 23, 2012, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.  C/O: #30100, #30121	ID PREFIX TAG N 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

Division of Health Care Facilities

*[Signature]*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

*Administrator*

(X5) DATE

8/31/12

STATE FORM

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If continuation sheet 1 of 1