

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN0505</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/20/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ASBURY PLACE AT MARYVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2648 SEVIERVILLE RD MARYVILLE, TN 37804</b>
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(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) COMPLETE DATE
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N 001	1200-8-6 Initial Comments  An Licensure survey and complaint investigations #32654, #33126, and #32643 were completed on March 20, 2014. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 001		
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Division of Health Care Facilities  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Ann L. Bran* Administrator TITLE  
*Re-Submitted* (X6) DATE  
*6/11/14*