

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0805	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT MARYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804
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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 This Rule is not met as evidenced by: An annual Licensure survey and complaint investigation #'s 30939, 30986, 30996, 30879, were completed on January 10, 2013, at Asbury Place at Maryville. No deficiencies were cited related to the complaint investigations under Chapter 1200-8-6, Standards for Nursing Homes.	N 001		
N 433	1200-8-6-.04(24) Administration (24)The facility shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public. Authority: T.C.A. §§4-5-202, 4-5-204, 39-17-1803, 39-17-1804, 39-17-1805, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-225, 68-11-254, 68-11-256, 68-11-257, 68-11-268, 68-11-308, and 71-6-121. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to post the charity care statement in an area easily accessible for public viewing. The findings included: Observation on January 7, 2012, at 9:55 a.m., revealed no posting of the facility's statement of charity care statement. Interview in the facility lobby with the Campus Executive Assistant on January 7, 2013, at 9:55 a.m., confirmed the facility's charity care	N 433	N-433 – No residents were affected by this deficiency. The Charity Care Policy was posted in the lobby on 1/7/13. Audit will be done monthly for 3 months to ensure the posting remains in the lobby. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	1/7/13

Division of Health Care Facilities

Alisa L. Brown

TITLE *Executive Director*

(X8) DATE

2-18-13

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

STATE FORM

6889

SX8Q11

if continuation sheet 1 of 2

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT MARYVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804		
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N 433	Continued From page 1 statement had not been posted as required.	N 433		