

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN8210</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/23/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ASBURY PLACE AT KINGSPORT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 NETHERLAND LANE KINGSPORT, TN 37660</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
N 000	<p><b>Initial Comments</b></p> <p>An annual licensure survey was conducted on October 21-23, 2013, at Asbury Place at Kingsport. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		

Division of Health Care Facilities

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

TITLE

(X6) DATE

STATE FORM

6899

585511

If continuation sheet 1 of 1

*James (Shelby) Smith MBA*

*Administrator*

*11/11/13*