Division of Health Care Facilities

PRINTED: 10/24/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8210	A. BUILDING: 01 - ASBURY PLACE AT KINGSPORT B. WING	10/21/2013

NAME OF PROVIDER OR SUPPLIER: ASBURY PLACE AT KINGSPORT

STREET ADDRESS, CITY, STATE, ZIP CODE: 100 NETHERLAND LANE, KINGSPORT, TN 37660

(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 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on October 21, 2013, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Shelton, Sr. MBA

TITLE: Administrator

(X6) DATE: 11/11/13

STATE FORM 6899 598S21

If continuation sheet 1 of 1