

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASBURY PLACE AT KING! B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2012
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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660
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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 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: Entity self-reported Incident # 2011113113653 and complaint investigation # TN00030807, was completed November 20, 2010. No deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.</p>	N 002		

Division of Health Care Facilities	TITLE	(X6) DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE