

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8210	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSFORT	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSFORT, 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)	(X6) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>A licensure survey and complaint investigation #36794 and #36935, were completed on 1/19-21/2016 at Asbury Place of 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 <i>Charlotte Moore Cochran LNHHA</i>	TITLE 	(X8) DATE <i>2-12-16</i>
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