

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>C</b> <b>08/03/2016</b>
--	---	---	---

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>
--	---

(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 complaint investigation of #38499, conducted on August 2, 2016 through August 3, 2016, at Asbury Place at Kingsport, no deficiencies were cited in relation to the complaint under Chapter 1200-8-6, Standards for Nursing Homes.	N 002		

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