

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>09/15/2015</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>Initial Comments</p> <p>Complaint investigation #35498 and #35728 was completed at Asbury Place at Kingsport was completed at John M. Reed Health and Rehab on 9/25/2015. 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 \_\_\_\_\_