

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9003 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2013 |
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| NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY | STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604 |
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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 |
|--------------------|--|---------------|---|--------------------|
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| N 002 | <p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: Entity and complaint investigation # TN00031994, was completed July, 2013. No deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.</p> | N 002 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

BRM521

If continuation sheet 1 of 1