

Division of Health Care Facilities

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 02/17/2010
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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
N 002	<p>1200-8-6 No Deficiencies</p> <p>During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-6, Standards for Nursing Homes.</p>	N 002		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE